

MONTANA LEGISLATIVE HISTORY

Chapter 595 1985

Bill H 817 S _____ Original bill & history ✓ c

H. Committee on Business + Labor

Hearing Date(s) Feb 18 ✓ c

Feb 19 ✓ c

_____ c

_____ c

Date Out Feb 15 ✓ c

S. Committee on Public Health Welfare & Safety

Hearing Date(s) Mar 11 ✓ c

Mar 13 ✓ c

_____ c

_____ c

Mar 13 ✓ c

Did this bill originate in an interim committee? ____ Yes ____ No

Committee _____

Report _____

HOUSE FINAL STATUS

PROGRAM

2/13	INTRODUCED		
2/13	REFERRED TO TAXATION		
2/13	FISCAL NOTE REQUESTED		
2/18	HEARING		
2/19	FISCAL NOTE RECEIVED		
2/22	COMMITTEE REPORT-NO RECOMMENDATION		
2/25	2ND READING PASS AS AMENDED	58	38
2/25	ON MOTION SEGREGATED FROM COMMITTEE OF WHOLE REPORT		
2/26	2ND READING PASS AS AMENDED	66	28
2/27	3RD READING PASS	60	40
	TRANSMITTED TO SENATE		
3/05	REFERRED TO TAXATION		
3/27	HEARING		
4/08	COMM REPORT-BILL CONCURRED AS AMENDED		
4/10	2ND READING CONCURRED AS AMENDED	39	5
4/12	3RD READING CONCURRED	43	7
	RETURNED TO HOUSE WITH AMENDMENTS		
4/15	2ND READING AMENDMENTS CONCURRED	91	6
4/16	3RD READING AMENDMENTS CONCURRED	87	6
4/18	SIGNED BY SPEAKER		
4/18	SIGNED BY PRESIDENT		
4/22	TRANSMITTED TO GOVERNOR		
4/25	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 634 EFFECTIVE DATE: 10/01/85		

HB 816 INTRODUCED BY M. WILLIAMS
HELVETICA BOLD LETTERING ON STATE FLAG

2/13	INTRODUCED		
2/13	REFERRED TO STATE ADMINISTRATION		
2/15	HEARING		
2/15	COMMITTEE REPORT-BILL DO PASS		
2/18	2ND READING PASS	94	3
2/19	3RD READING PASS	97	1
	TRANSMITTED TO SENATE		
2/21	REFERRED TO STATE ADMINISTRATION		
3/20	HEARING		
3/20	COMMITTEE REPORT-BILL CONCURRED		
3/23	2ND READING CONCURRED	49	0
3/26	3RD READING CONCURRED	50	0
	RETURNED TO HOUSE		
3/28	SIGNED BY SPEAKER		
3/28	SIGNED BY PRESIDENT		
3/29	TRANSMITTED TO GOVERNOR		
4/02	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 335 EFFECTIVE DATE: 10/01/85		

HB 817 INTRODUCED BY KITSELMAN, ECK, ET AL.
HEALTH INSURANCE POOLING ACT

2/13 INTRODUCED

HOUSE FINAL STATUS

2/13	REFERRED TO BUSINESS & LABOR		
2/13	FISCAL NOTE REQUESTED		
2/18	HEARING		
2/19	FISCAL NOTE RECEIVED		
2/20	COMMITTEE REPORT-BILL PASS AS AMENDED		
2/20	STATEMENT OF INTENT ATTACHED		
2/22	2ND READING PASS	94	0
2/23	3RD READING PASS	93	0

TRANSMITTED TO SENATE			
3/04	REFERRED TO PUBLIC HEALTH, WELFARE & SAFETY		
3/11	HEARING		
3/14	COMM REPORT-BILL CONCURRED AS AMENDED		
3/21	2ND READING CONCURRED	48	0
3/23	3RD READING CONCURRED	49	0

RETURNED TO HOUSE WITH AMENDMENTS			
4/08	2ND READING AMENDMENTS CONCURRED	91	5
4/08	ON MOTION RULES SUSPENDED		
	PLACED ON 3RD READING THIS DAY		
4/08	3RD READING AMENDMENTS CONCURRED	94	3
4/15	SIGNED BY SPEAKER		
4/15	SIGNED BY PRESIDENT		

4/17	TRANSMITTED TO GOVERNOR		
4/22	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 595 EFFECTIVE DATE: 7/01/85		
	SECTION 5 EFFECTIVE 7/1/87		

HB 818 INTRODUCED BY PATTERSON, D. BROWN, BENGTSON
COUNTY CONTRIBUTION TO MUSEUM NOT OWNED BY COUNTY
BY REQUEST OF HOUSE LOCAL GOVERNMENT

2/13	INTRODUCED		
2/13	REFERRED TO LOCAL GOVERNMENT		
2/14	HEARING		
2/15	COMMITTEE REPORT-BILL PASS AS AMENDED		
2/19	2ND READING PASS	91	3
2/20	3RD READING PASS	92	7

TRANSMITTED TO SENATE			
2/22	REFERRED TO LOCAL GOVERNMENT		
3/28	HEARING		
3/29	COMMITTEE REPORT-BILL CONCURRED		
3/29	ON MOTION RULES SUSPENDED		
	PLACED ON 3RD READING 70TH DAY		
4/01	2ND READING CONCURRED	45	0
4/01	3RD READING CONCURRED	46	4

RETURNED TO HOUSE			
4/08	SIGNED BY SPEAKER		
4/08	SIGNED BY PRESIDENT		
4/08	TRANSMITTED TO GOVERNOR		
4/12	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 455 EFFECTIVE DATE: 7/01/85		

HB 819 INTRODUCED BY KRUEGER, D. BROWN
AGRICULTURAL SUPPLIERS LIEN

HOUSE BILL NO. 817

INTRODUCED BY KITSelman, ECK, JACOBSON, WINSLOW,
HAGER, KENNERLY, THOMAS, GOULD, BERGENE, GILBERT

IN THE HOUSE

February 13, 1985	Introduced and referred to Committee on Business and Labor. Fiscal Note requested.
February 18, 1985	On motion by Chief Sponsor, Representatives Gould, Thomas, Bergene, and Gilbert were added as sponsors.
February 19, 1985	Fiscal Note returned.
February 20, 1985	Committee recommend bill do pass as amended. Report adopted. Statement of Intent attached. Bill printed and placed on members' desks.
February 22, 1985	Second reading, do pass. Considered correctly engrossed.
February 23, 1985	Third reading, passed. Transmitted to Senate.

IN THE SENATE

March 4, 1985	Introduced and referred to Committee on Public Health, Welfare and Safety.
March 14, 1985	Committee recommend bill be concurrent in as amended. Report adopted.

4

March 18, 1985

Second reading, pass
consideration.

March 21, 1985

Second reading, concurred in.

March 23, 1985

Third reading, concurred in.
Ayes, 49; Noes, 0.

Returned to House with
amendments.

IN THE HOUSE

March 25, 1985

Received from Senate.

April 8, 1985

Second reading, amendments
concurred in.

On motion, rules suspended and
bill placed on third reading
this day.

Third reading, amendments
concurred in.

Sent to enrolling.

Reported correctly enrolled.

1 HOUSE BILL NO. 817
2 INTRODUCED BY Kibelman Erik Jacobson Winters
3 Hager Kennedy
4 A BILL FOR AN ACT ENTITLED: "AN ACT TO PROVIDE HEALTH
5 INSURANCE COVERAGE TO CERTAIN PERSONS INELIGIBLE FOR
6 COVERAGE FROM TRADITIONAL PROVIDERS OF HEALTH CARE BENEFITS
7 BY ESTABLISHING A COMPREHENSIVE HEALTH ASSOCIATION AND PLAN;
8 TO REQUIRE PARTICIPATION IN THE ASSOCIATION BY EACH HEALTH
9 SERVICE CORPORATION, FRATERNAL BENEFIT SOCIETY, AND INSURER
10 PROVIDING HEALTH CARE BENEFITS IN THIS STATE; AND PROVIDING
11 EFFECTIVE DATES."
12
13 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:
14 Section 1. Definitions. As used in [sections 1 through
15 12], the following definitions apply:
16 (1) "Association" means the comprehensive health
17 association created by [section 3].
18 (2) "Association plan" means a policy of insurance
19 coverage offered by the association through the lead
20 carrier.
21 (3) "Association plan premium" means the charge
22 determined pursuant to [section 8] for membership in the
23 association plan based on the benefits provided in [section
24 6].
25 (4) "Eligible person" means an individual who:

1 (a) is a resident of this state and has been a
2 resident for at least 1 year immediately preceding
3 application for coverage under the association plan; and
4 (b) within 6 months prior to the date of application,
5 has been rejected for disability insurance or health service
6 benefits by at least two insurers, societies, or health
7 service corporations, or has had a restrictive rider or
8 preexisting conditions limitation, which limitation is
9 required by at least two insurers, societies, or health
10 service corporations, which has the effect of substantially
11 reducing coverage from that received by a person considered
12 a standard risk.
13 (5) "Health service corporation" means a corporation
14 operating pursuant to Title 33, chapter 30, and offering or
15 selling contracts of disability insurance.
16 (6) "Insurer" means a company operating pursuant to
17 Title 33, chapter 2 or 3, and offering or selling policies
18 or contracts of disability insurance, as provided in Title
19 33, chapter 22.
20 (7) "Lead carrier" means the licensed administrator or
21 insurer selected by the association to administer the
22 association plan.
23 (8) "Preexisting condition" means any condition for
24 which an applicant for coverage under the association plan
25 has received medical attention during the 5 years

1 immediately preceding the filing of an application.

2 (9) "Qualified plan" means those health benefit plans
3 certified by the commissioner as providing the minimum
4 benefits required by [section 6] or the actuarial equivalent
5 of those benefits.

6 (10) "Society" means a fraternal benefit society
7 operating pursuant to Title 33, chapter 7, and offering or
8 selling certificates of disability insurance.

9 Section 2. Duties of the commissioner -- rules. The
10 commissioner shall:

11 (1) adopt rules to carry out the provisions and
12 purposes of [sections 1 through 12];

13 (2) supervise the creation of the association within
14 the limits described in [section 3];

15 (3) approve the selection of the lead carrier by the
16 association and approve the association's contract with the
17 lead carrier, including the association plan coverage and
18 premiums to be charged;

19 (4) conduct periodic audits to assure the general
20 accuracy of the financial data submitted by the lead carrier
21 and the association; and

22 (5) undertake, directly or through contracts with
23 other persons, studies or demonstration projects to develop
24 awareness of the benefits of [sections 1 through 12] so that
25 the residents of this state may best avail themselves of the

1 health care benefits provided by [sections 1 through 12].

2 Section 3. Comprehensive health association --
3 mandatory membership.

4 (1) There is established a comprehensive health
5 association with participating membership consisting of all
6 insurers, societies, and health service corporations
7 licensed or authorized to do business in this state. The
8 association is exempt from taxation under the laws of this
9 state, and all property owned by the association is exempt
10 from taxation.

11 (2) All participating members shall maintain their
12 membership in the association as a condition for writing
13 health care benefits policies or contracts in this state.
14 The association shall submit its articles, bylaws, and
15 operating rules to the commissioner for approval.

16 (3) The association may:

17 (a) exercise the powers granted to insurers under the
18 laws of this state;

19 (b) sue or be sued;

20 (c) enter into contracts with insurers,
21 administrators, similar associations in other states, or
22 other persons for the performance of administrative
23 functions;

24 (d) establish administrative and accounting procedures
25 for the operation of the association;

1 (e) provide for the reinsuring of risks incurred as a
2 result of issuing the coverages required by members of the
3 association; and

4 (f) provide for the administration by the association
5 of policies that are reinsured pursuant to subsection
6 (3)(e).

7 Section 4. Association board of directors --
8 organization. (1) There is a board of directors of the
9 association, consisting of eight individuals:

10 (a) one from each of the seven participating members
11 of the association with the highest annual premium volume of
12 disability insurance contracts or health service corporation
13 contracts, derived from or on behalf of residents in the
14 previous calendar year, as determined by the commissioner;
15 and

16 (b) a member at large, appointed by the commissioner
17 to represent the public interest, who shall serve in an
18 advisory capacity only.

19 (2) Each of the seven board members representing the
20 association members is entitled to vote, in person or by
21 proxy, based on the association member's annual premium
22 volume, in accordance with the following schedule:

23 \$ 100,000 -- \$ 4,999,999	1 vote
24 5,000,000 -- 9,999,999	2 votes
25 10,000,000 -- 14,999,999	3 votes

1 15,000,000 or more 4 votes

2 (3) Members of the board may be reimbursed from the
3 money of the association for expenses incurred by them due
4 to their service as board members but may not otherwise be
5 compensated by the association for their services. The costs
6 of conducting the meetings of the association and its board
7 of directors must be borne by participating members of the
8 association in accordance with [section 9].

9 Section 5. Minimum benefits of association plan. The
10 association through the association plan shall offer a
11 policy that provides at least the benefits of a qualified
12 plan as required by [section 6].

13 Section 6. Qualified plan -- minimum benefits. A plan
14 of health coverage must be certified as a qualified plan if
15 it otherwise meets the requirements of Title 33, chapters
16 15, 22, and 30, and other laws of this state, whether or not
17 the policy is issued in this state, and meets or exceeds the
18 following minimum standards:

19 (1) The minimum benefits for an insured must, subject
20 to the other provisions of this section, be equal to at
21 least 80% of the covered expenses required by this section
22 in excess of an annual deductible that does not exceed
23 \$1,000 per person. The coverage must include a limitation of
24 \$5,000 per person on the total annual out-of-pocket expenses
25 for services covered under this section. Coverage must be

subject to a maximum lifetime benefit, but such maximums may not be less than \$100,000.

(2) Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician or other licensed health care professional provided for in 33-22-111:

(a) hospital services;

(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;

(c) use of radium or other radioactive materials;

(d) oxygen;

(e) anesthetics;

(f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3);

(g) services of a physical therapist;

(h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;

(i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;

(j) rental or purchase of medical equipment, which shall be reimbursed after the deductible has been met at the rate of 50%, up to a maximum of \$1,000;

(k) prosthetics, other than dental;

(l) services of a licensed home health agency, up to a maximum of 180 visits per year; and

(m) necessary care and treatment of mental illness, alcoholism, and drug addiction, as provided in 33-22-703.

(3) (a) Covered expenses for the services or articles specified in this section do not include:

(i) drugs requiring a physician's prescription;

(ii) services of a nursing home;

(iii) home and office calls, except as specifically provided in subsection (2);

(iv) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

(v) the first \$20 of diagnostic x-ray and laboratory charges in each 14-day period;

(vi) oral surgery, except as specifically provided in subsection (2);

(vii) that part of a charge for services or articles which exceeds the prevailing charge in the locality where the service is provided; or

(viii) care that is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

1 (i) care or for any injury or disease either arising
 2 out of an injury in the course of employment and subject to
 3 a workers' compensation or similar law, for which benefits
 4 are payable without regard to fault under coverage
 5 statutorily required to be contained in any motor vehicle or
 6 other liability insurance policy or equivalent
 7 self-insurance, or for which benefits are payable under
 8 another policy of disability insurance or medicare;

9 (ii) treatment for cosmetic purposes other than surgery
 10 for the repair or treatment of an injury or congenital
 11 bodily defect to restore normal bodily functions;

12 (iii) travel other than transportation provided by a
 13 licensed ambulance service to the nearest facility qualified
 14 to treat the condition;

15 (iv) confinement in a private room to the extent it is
 16 in excess of the institution's charge for its most common
 17 semiprivate room, unless the private room is prescribed as
 18 medically necessary by a physician;

19 (v) services or articles the provision of which is not
 20 within the scope of authorized practice of the institution
 21 or individual rendering the services or articles;

22 (vi) organ transplants unless prior approval is
 23 received from the board of directors of the association;

24 (vii) room and board for a nonemergency admission on
 25 Friday or Saturday;

1 (viii) pregnancy, except complications of pregnancy;

2 (ix) routine well baby care;

3 (x) complications to a newborn, unless no other source
 4 of coverage is available;

5 (xi) sterilization or reversal of sterilization;

6 (xii) abortion, unless the life of the mother would be
 7 endangered if the fetus were carried to term;

8 (xiii) weight modification or modification of the body
 9 to improve the mental or emotional well-being of an insured;

10 (xiv) artificial insemination or treatment for
 11 infertility; or

12 (xv) breast augmentation or reduction.

13 Section 7. Certification of qualified plan. Upon
 14 application by the association or the lead carrier for
 15 certification of a plan of health coverage as a qualified
 16 plan for the purposes of [sections 1 through 12], the
 17 commissioner shall make a determination within 90 days as to
 18 whether the plan is qualified. If determined to be
 19 qualified, the plan of health coverage must be labeled as a
 20 "qualified plan" on the front of the policy.

21 Section 8. Association plan premium. The association
 22 shall establish the schedule of premiums to be charged
 23 eligible persons for membership in the association plan. The
 24 schedule of premiums may not be less than 150% or more than
 25 400% of the average premium rates charged by the five

1 largest insurers with the largest individual qualified plan
 2 of insurance in force in this state. The premium rates of
 3 the five insurers used to establish the premium rates for
 4 each type of coverage offered by the association must be
 5 determined by the commissioner from information provided
 6 annually by all insurers at the request of the commissioner.
 7 The information requested must include the number of
 8 qualified plans or actuarial equivalent plans offered by
 9 each insurer, the rates charged by the insurer for each type
 10 of plan offered by the insurer, and any other information
 11 the commissioner considers necessary. The commissioner shall
 12 utilize generally acceptable actuarial principles and
 13 structurally compatible rates.

14 Section 9. Operation of association plan. (1) Upon
 15 acceptance by the lead carrier under [section 12], an
 16 eligible person may enroll in the association plan by
 17 payment of the association plan premium to the lead carrier.

18 (2) Not less than 90% of the association plan premiums
 19 paid to the lead carrier may be used to pay claims and not
 20 more than 10% may be used for payment of the lead carrier's
 21 direct and indirect expenses as specified in [section 10].

22 (3) Any income in excess of the costs incurred by the
 23 association in providing reinsurance or administrative
 24 services must be held at interest and used by the
 25 association to offset past and future losses due to claims

1 expenses of the association plan or be allocated to reduce
 2 association plan premiums.

3 (4) Each participating member of the association shall
 4 share the losses due to claims expenses of the association
 5 plan for plans issued or approved for issuance by the
 6 association and shall share in the operating and
 7 administrative expenses incurred or estimated to be incurred
 8 by the association incident to the conduct of its affairs.
 9 Claims expenses of the association plan that exceed the
 10 premium payments allocated to the payment of benefits are
 11 the liability of the association members. Association
 12 members shall share in the claims expenses of the
 13 association plan and operating and administrative expenses
 14 of the association in an amount equal to the ratio of:

15 (a) the association member's total disability
 16 insurance premium received from or on behalf of Montana
 17 residents divided by;

18 (b) the total disability premium received by all
 19 association members from or on behalf of Montana residents,
 20 as determined by the commissioner.

21 (5) The association shall make an annual determination
 22 of each association member's liability, if any, and may make
 23 an annual fiscal yearend assessment if necessary. The
 24 association may also, subject to the approval of the
 25 commissioner, provide for interim assessments against the

1 association members as may be necessary to assure the
2 financial capability of the association in meeting the
3 incurred or estimated claims expenses of the association
4 plan and operating and administrative expenses of the
5 association until the association's next annual fiscal
6 yearend assessment. Payment of an assessment is due within
7 30 days of receipt by an association member of a written
8 notice of a fiscal yearend or interim assessment. Failure
9 by a contributing member to tender to the association the
10 assessment within 30 days is grounds for termination of
11 membership. An association member that ceases to do
12 disability insurance business within the state remains
13 liable for assessments through the calendar year during
14 which disability insurance business ceased. The association
15 may decline to levy an assessment against an association
16 member if the assessment, as determined pursuant to this
17 section, would not exceed \$10.

18 (6) Any annual fiscal yearend or interim assessment
19 levied against an association member may be offset, in an
20 amount equal to the assessment paid to the association,
21 against the premium tax payable by that association member
22 pursuant to 33-2-705 for the year in which the annual fiscal
23 yearend or interim assessment is levied. The department of
24 revenue shall, each year the legislature meets in regular
25 session, on or before January 15, report to the legislature

1 the total amount of premium tax offset claimed by
2 association members during the preceding biennium.

3 Section 10. Administration of association plan --
4 rules. (1) Any member of the association may submit to the
5 commissioner policies to be proposed to serve as the
6 association plan. The commissioner shall prescribe by rule
7 the time and manner of the submission.

8 (2) Upon the commissioner's approval of the policy
9 forms and contracts submitted, the association shall select
10 policies and contracts by a member or members of the
11 association to be the association plan. The association
12 shall select one lead carrier to issue the qualified plans.
13 The board of directors of the association shall prepare
14 appropriate specifications and bid forms and may solicit
15 bids from licensed administrators and the members of the
16 association for the purpose of selecting the lead carrier.
17 The selection of the lead carrier must be based upon
18 criteria established by the board of directors.

19 (3) The lead carrier shall perform all administrative
20 and claims payment functions required by this section upon
21 the commissioner's approval of the policy forms and
22 contracts submitted. The lead carrier shall provide these
23 services for a period of at least 3 years, unless a request
24 to terminate is approved by the association and the
25 commissioner. The association and the commissioner shall

1 approve or deny a request to terminate within 90 days of its
2 receipt. A failure to make a final decision on a request to
3 terminate within the specified period is considered an
4 approval. The association shall invite submissions of policy
5 forms from members of the association, including the lead
6 carrier, 6 months prior to the expiration of each 3-year
7 period. The association shall follow the procedure provided
8 in subsection (2) in selecting a lead carrier for the
9 subsequent 3-year period or, if a request to terminate is
10 approved, on or before the end of the 3-year period.

11 (4) The lead carrier shall provide all eligible
12 persons involved in the association plan an individual
13 certificate setting forth a statement as to the insurance
14 protection to which the person is entitled, the method and
15 place of filing claims, and to whom benefits are payable.
16 The certificate must indicate that coverage was obtained
17 through the association.

18 (5) The lead carrier shall submit to the association
19 and the commissioner on a semiannual basis a report of the
20 operation of the association plan. The association must
21 determine the specific information to be contained in the
22 report prior to the effective date of the association plan.

23 (6) The lead carrier shall pay all claims pursuant to
24 [sections 1 through 12] and shall indicate that the claim
25 was paid by the association plan. Each claim payment must

1 include information specifying the procedure involved in the
2 event a dispute over the amount of payment arises.

3 (7) The lead carrier must be reimbursed from the
4 association plan premiums received for its direct and
5 indirect expenses. Direct and indirect expenses include a
6 prorated reimbursement for the portion of the lead carrier's
7 administrative, printing, claims administration, management,
8 and building overhead expenses, which are assignable to the
9 maintenance and administration of the association plan. The
10 association must approve cost accounting methods to
11 substantiate the lead carrier's cost reports consistent with
12 generally accepted accounting principles. Direct and
13 indirect expenses may not include costs directly related to
14 the original submission of policy forms prior to selection
15 as the lead carrier.

16 (8) The lead carrier is, when carrying out its duties
17 under [sections 1 through 12], an agent of the association
18 and is civilly liable for its actions, subject to the laws
19 of this state.

20 Section 11. Solicitation of eligible persons. (1) The
21 association, pursuant to a plan approved by the
22 commissioner, shall disseminate appropriate information to
23 the residents of this state regarding the existence of the
24 association plan and the means of enrollment. Means of
25 communication may include use of the press, radio, and

1 television, as well as publication in appropriate state
2 offices and publications.

3 (2) The association shall devise and implement means
4 of maintaining public awareness of [sections 1 through 12]
5 and shall administer [sections 1 through 12] in a manner
6 which facilitates public participation in the association
7 plan.

8 (3) All licensed disability insurance agents may
9 engage in the selling or marketing of qualified association
10 plans. The lead carrier shall pay an agent's referral fee of
11 \$25 to each licensed disability insurance agent who refers
12 an applicant to the association plan, if the applicant is
13 accepted. The referral fees must be paid to the lead
14 carrier from money received as premiums for the association
15 plan.

16 (4) An insurer, society, or health service corporation
17 that rejects or applies underwriting restrictions to an
18 applicant for disability insurance must notify the applicant
19 of the existence of the association plan, requirements for
20 being accepted in it, and the procedure for applying to it.

21 Section 12. Enrollment by eligible person. (1) The
22 association plan must be open for enrollment by eligible
23 persons. An eligible person may enroll in the plan by
24 submission of a certificate of eligibility to the lead
25 carrier. The certificate must provide:

1 (a) the name, address, and age of the applicant and
2 length of the applicant's residence in this state;

3 (b) the name, address, and age of spouse and children,
4 if any, if they are to be insured;

5 (c) written evidence that he fulfills all of the
6 elements of an eligible person, as defined in [section 1];
7 and

8 (d) a designation of coverage desired.

9 (2) Within 30 days of receipt of the certificate, the
10 lead carrier shall either reject the application for failing
11 to comply with the requirements of subsection (1) or forward
12 the eligible person a notice of acceptance and billing
13 information. Insurance is effective immediately upon receipt
14 of the first month's association plan premium and is
15 retroactive to the date of application, if the applicant
16 otherwise complies with [sections 1 through 12].

17 (3) An eligible person may not purchase more than one
18 policy from the association plan.

19 (4) A person who obtains coverage pursuant to this
20 section may not be covered for any preexisting condition
21 during the first 12 months of coverage under the association
22 plan if the person was diagnosed or treated for that
23 condition during the 5 years immediately preceding the
24 filing of an application. This subsection does not apply to
25 a person who has had continuous coverage under an

1 individual, family, or group policy during the year
2 immediately preceding the filing of an application for
3 nonelective procedures.

4 Section 13. Extension of authority. Any existing
5 authority of the commissioner of insurance to make rules on
6 the subject of the provisions of this act is extended to the
7 provisions of this act.

8 Section 14. Codification instruction. Sections 1
9 through 12 are intended to be codified as an integral part
10 of Title 33, and the provisions of Title 33 apply to
11 sections 1 through 12.

12 Section 15. Severability. If a part of this act is
13 invalid, all valid parts that are severable from the invalid
14 part remain in effect. If a part of this act is invalid in
15 one or more of its applications, the part remains in effect
16 in all valid applications that are severable from the
17 invalid applications.

18 Section 16. Effective date. (1) Except for section 5,
19 this act is effective July 1, 1985.

20 (2) Section 5 is effective July 1, 1987.

-End-

In compliance with a written request received February 13, 19 85, there is hereby submitted a Fiscal Note for House Bill 817 pursuant to Title 5, Chapter 4, Part 2 of the Montana Code Annotated (MCA). Background information used in developing this Fiscal Note is available from the Office of Budget and Program Planning, to members of the Legislature upon request.

DESCRIPTION OF PROPOSED LEGISLATION:

House Bill 817 creates a Comprehensive Health Association and plan to provide health insurance coverage to certain persons ineligible for coverage from traditional providers of health care benefits. Each Health Service Corporation, Fraternal Benefit Society and Insurer is required to participate in the association.

ASSUMPTIONS:

1. No revenue generated for the State. Premiums will be to cover cost of claims and association administrative costs.
2. Assume no additional STAFF will be required to administer the program.
3. Assume Financial Examiner costs for FY 1986 and every (3) three years thereafter.
4. Actuary required for initial start-up FY 1986 and in FY 1987; examine once every (3) three years thereafter.
5. Additional communication costs for biennium.
6. Additional hearing and rulemaking costs for FY 1986.

FISCAL IMPACT:

Expenditures:

	<u>Existing Law</u>	<u>Proposed Law</u>	<u>Existing Law</u>	<u>Proposed Law</u>
Operating	-0-	\$ 4,900	-0-	\$ 1,925
		\$ 4,900	-0-	\$ 1,925
TOTAL	-0-			
Total General Fund Cost	-0-	\$ 4,900	-0-	\$ 1,925

David L. Hunter
BUDGET DIRECTOR
Office of Budget and Program Planning

Date: Feb 19, 1985
HB 817

LONG-RANGE EFFECTS OF PROPOSED LEGISLATION:

Premium tax revenue to the General Fund may be impacted in future years. When claims exceed revenue raised through premiums paid by covered individuals, each insurer in the association will be assessed. That assessment can be offset against premium taxes owed to Montana.

TECHNICAL OR MECHANICAL DEFECTS OR CONFLICTS WITH EXISTING LEGISLATION:

Section 9, Paragraph (6) 1.23 and 24, Recommend change from "Department of Revenue" to "The Insurance Commissioner".

Section 6 (3) (i) appears to address "no-fault" insurance which is not appropriate to Montana.

STATUS SHEET

49TH

LEGISLATIVE SESSION

COMMITTEE ON BUSINESS AND LABOR

HOUSE BILL NO.	ENTERED COMM.	DATE CONSIDERED	OUT OF COMM.	DO PASS DATE	DO NOT PASS DATE	DO PASS AS AMEND. DATE	BE CON- CURRED IN DATE	BE CONC. IN AS AMENDED DATE	BE NOT CON- CURRED IN DATE
728	2-8	2-18/2-19 2-20	2-20		2-20				
759	2-9	2-13	2-13	2-13					
773	2-11	2-15/2-19		TABLED AS AMENDED					
811	2-13	2-20/2-21							
817	2-13	2-18/2-19	2-19			2-19			
819	2-14	2-20/2-21	2-21			2-21			
825	2-14	2-20	2-20			2-20			
840	2-15	2-21/2-22	2-22			2-22			
852	2-15	2-21/2-22	2-22			2-22			
853	2-16	2-21/2-22	2-22			2-22			
855	2-16	2-21/2-22	2-22			2-22			
863	2-16	2-21/2-22	2-22		2-22				
868	2-18	2-22	2-22		2-22				
874	2-18	2-22	2-22		2-22				
877	2-19	2-22	2-22			2-22			
880	2-19	2-22/2-23	2-23			2-23			

Use a separate sheet for Senate, House Bills, and Resolutions

MINUTES OF THE MEETING
BUSINESS AND LABOR COMMITTEE
MONTANA STATE
HOUSE OF REPRESENTATIVES

February 18, 1985

The meeting of the Business and Labor Committee was called to order by Chairman Bob Pavlovich, on February 18, 1985 at 7:30 a.m., in Room 312-2 of the State Capitol.

ROLL CALL: All members were present.

ACTION ON HOUSE BILL 354: Rep. Brandewie moved that House Bill 354 DO PASS. Rep. Glaser explained that more is at stake than seaplanes, smaller airports could be forced out of business if fees are to be charged. A roll call vote resulted in 11 members voting yes and 8 members voted no. House Bill 354 DO PASS.

ACTION ON HOUSE BILL 668: Rep. Kitselman told the committee that this bill will effect 1/10 of 1% of the premium market. Rep. Glaser suggested that the committee defer action until Rep. Kitselman's House Bill 817 is heard. Rep. Thomas added that this bill is not able to work financially. House Bill 668 will be held until House Bill 817 is heard.

ACTION ON HOUSE BILL 691: Rep. Kitselman made a motion that House Bill 691 be TABLED. Rep. Ellerd made a substitute motion that House Bill 691 DO NOT PASS. A roll call vote resulted in 12 members voting yes and 8 members voting no. House Bill 691 DO NOT PASS.

ACTION ON HOUSE BILL 568: Chairman Pavlovich explained to the committee that the sponsor of the bill requested the committee reconsider their action. Rep. Driscoll moved that the committee reconsider. The motion did fail, House Bill 568 will not be reconsidered.

ACTION ON HOUSE BILL 338: Rep. Brandewie moved that House Bill 338 be taken from the TABLE. Rep. Hansen offered a substitute motion that House Bill 338 remain TABLED. The motion did fail, with 9 members voting yes and 11 members voting no. Rep. Thomas moved that House Bill 338 DO PASS. Rep. Jones moved the amendments which are attached hereto as Exhibit 1. The amendments DO PASS unanimously. Rep. Kadas added that House Bill 338 as amended will answer the big problems in the industry, but not the little problems. A roll call vote found 13 members voting yes and 7 members voting no. House Bill 338 DO PASS AS AMENDED.

HOUSE BILL 634: Hearing commenced on House Bill 634. Rep. Earl Lory, District #59, sponsor of the bill by request of the Securities Division, stated this sets up a special revenue account in which to deposit fees, examination charges and miscellaneous charges collected by the division while fines and penalties are deposited in the general fund.

Proponent Andrea Bennett, State Auditor, supplied written testimony which is attached hereto as Exhibit 2.

There being no further discussion by proponents and no opponents to the bill, all were excused by the chairman and the hearing on House Bill 634 was closed.

HOUSE BILL 817: Hearing commenced on House Bill 817. Rep. Les Kitseiman, District #95, sponsor of the bill, explained this authorizes establishment of a comprehensive health association and plan to provide health insurance coverage to certain persons ineligible for coverage from traditional providers of health care benefits.

Proponent Marie Deonier, representing Montana Association of Health Underwriters, supplied written testimony which is attached hereto as Exhibit 3.

Proponent Steve Davis, representing the Disabilities Coalition, offered his support.

Proponent Stanlee Dau, Executive Director, American Diabetes Association, Montana Affiliate, Inc., supplied written testimony which is attached hereto as Exhibit 4.

Proponents Marilyn Moore, representing the American Diabetes Association, Barbara Penner, representing the American Heart Association, Elmer Hansken, representing Montana Association of Life Underwriters and Riley Johnson, representing Professional Insurance Agents, all offered their support of the bill.

Proponent John Alke, representing the Montana Physicians Surgeons and Blue Shield offered his support of the bill as amended.

Proponent Bill Jensen, representing Blue Cross, explained that House Bill 817 creates a good, workable solution.

Proponent Rick Bach, representing the Insurance Commission, proposed amendments to the bill which are attached hereto as Exhibit 5.

Proponent Robert Steil, representing Health Insurance Association of American, explained that there are problems with self-insured plans. Approximately 88% of insureds are covered under a group plan, added Mr. Steil.

In closing, Rep. Kitselman read to committee members a letter from Ms. Kathy Barkell, which is attached hereto as Exhibit 6.

Rep. Glaser asked John Alke if a person has existing coverage and is a high risk individual, can they be dropped from the group. Mr. Alke explained that they can and they would be able to convert their policy. Rep. Glaser then raised a question concerning a state resident, as provided in the bill. A state resident is as defined by the election laws was the clarification.

Rep. Schultz asked Bill Jensen if the bill will enable a group insurance plan to strip those high risk individuals from the plan. Mr. Jensen replied that they cannot.

There being no further discussion by proponents or opponents, all were excused by the chairman and the hearing on House Bill 817 was closed.

HOUSE BILL 694: Hearing commenced on House Bill 694. Rep. Tom Asay, District #27, sponsor of the bill explained this revises the law on utility purchases from qualifying small power production facilities at avoided cost. If the utility is able to buy power from a power pool, the avoided cost is the price charged by the power pool. If the utility has excess generating capacity, the avoided cost of capacity is zero and the avoided cost of energy is equal to the utility's incremental running cost, added Rep. Asay.

Proponent Dick Cromer, Director, Resource Planning, Montana Power Company, supplied written testimony which is attached hereto as Exhibit 7. Mr. Cromer also supplied a visual aid depicting a motel which illustrated the scenario of House Bill 694.

Proponent Gene Phillips, representing Pacific Power and Light, stated that this electric utility operates in 6 western states and the effects on Pacific Power and Light would be different.

DAILY ROLL CALL
BUSINESS AND LABOR COMMITTEE

49th LEGISLATIVE SESSION -- 1985

Date February 18, 1985

NAME	PRESENT	ABSENT	EXCUSED
Bob Pavlovich	✓		
Les Kitselman	✓		
Bob Bachini	✓		
Ray Brandewie	✓		
Jan Brown	✓		
Jerry Driscoll	✓		
Robert Ellerd	✓		
William Glaser	✓		
Stella Jean Hansen	✓		
Marjorie Hart	✓		
Ramona Howe	✓		
Tom Jones	✓		
Mike Kadas	✓		
Vernon Keller	✓		
Lloyd McCormich	✓		
Jerry Nisbet	✓		
James Schultz	✓		
Bruce Simon	✓		
Fred Thomas	✓		
Norm Wallin	✓		

Exhibit 3

2/18/85

House Bill 817

Submitted by: Marie Deonier

TESTIMONY OF MARIE DEONIER, RHU

ON

HOUSE BILL # 817

"AN ACT TO PROVIDE HEALTH INSURANCE COVERAGE TO CERTAIN PERSONS INELIGIBLE FOR COVERAGE FROM TRADITIONAL PROVIDERS OF HEALTH CARE BENEFITS BY ESTABLISHING A COMPREHENSIVE HEALTH ASSOCIATION AND PLAN; TO REQUIRE PARTICIPATION IN THE ASSOCIATION BY EACH HEALTH SERVICE CORPORATION, FRATERNAL BENEFIT SOCIETY, AND INSURER PROVIDING HEALTH CARE BENEFITS IN THIS STATE; AND PROVIDING AN EFFECTIVE DATE."

ON BEHALF OF

MONTANA ASSOCIATION OF HEALTH UNDERWRITERS

MY NAME IS MARIE DEONIER, RHU (REGISTERED HEALTH UNDERWRITER). I AM A MEMBER OF THE MONTANA ASSOCIATION OF HEALTH UNDERWRITERS OF WHICH I AM THE CURRENT PRESIDENT ELECT AND CHAIRMAN OF THE LEGISLATIVE COMMITTEE. I AM ALSO A MEMEBER OF THE MONTANA ASSOCIATION OF LIFE UNDERWRITERS, AND LEGISLATIVE CO-CHAIRMAN OF THE SOUTHEASTERN MONTANA ASSOCIATION OF LIFE UNDERWRITERS.

I AM APPEARING ON BEHALF OF THE MONTANA ASSOCIATION OF HEALTH UNDERWRITERS AND MYSELF, AN INFORMED INSURANCE AGENT WHO IS CONCERNED ABOUT THE HEALTH INSURANCE NEEDS OF ALL PERSONS RESIDING IN THE STATE OF MONTANA.

MANY MONTANAN'S ARE PRESENTLY UNABLE TO PURCHASE MEDICAL INSURANCE BECAUSE OF MEDICAL PROBLEMS SUCH AS DIABETES, CANCER, HEART, EPILEPSY, PHYSICAL HANDICAPS, LUNG DISEASES, CEREBRAL PALSY, TO NAME A FEW.

MOST OF US HERE TODAY KNOW OR KNOW OF SOMEONE WHO WOULD FALL INTO THE CATEGORY OF "UNINSURABLE DUE TO MEDICAL REASONS".

AS AN INSURANCE AGENT SPECIALIZING IN THE HEALTH INSURANCE MARKET I FREQUENTLY RECIEVE CALLS FROM PERSONS WHO HAVE BEEN

DECLINED BY INSURANCE COMPANIES FOR MEDICAL INSURANCE OR WHO HAVE BEEN ISSUED A POLICY WITH EXCLUSIONS FOR THE CONDITION FOR WHICH THEY NEED THE INSURANCE COVERAGE THE MOST. A TYPICAL EXAMPLE BEING: EXCLUSION OF HEART AND CIRCULATORY SYSTEM FOR A PERSON WHO HAS HAD A HEART ATTACK OR WHO HAS HIGH BLOOD PRESSURE.

IT IS THEREFORE MY FEELING AS A CONCERNED PERSON AND INSURANCE AGENT THAT THERE NEEDS TO BE A WAY TO OFFER MEDICAL INSURANCE COVERAGE TO THESE PERSONS WHICH WILL NOT ONLY OFFER THAT PERSON A MEDICAL INSURANCE POLICY, BUT ONE THAT WILL NOT ISSUE EXCLUSIONS. THEREFORE, THE MONTANA ASSOCIATION OF HEALTH UNDERWRITERS DECIDED TO BACK THIS BILL WHICH IS BEING PRESENTED TO YOU TODAY.

BY MAKING A PLAN OF INSURANCE AVAILABLE TO THESE PEOPLE IT IS POSSIBLE THAT IT WILL PREVENT THOSE SAME PERSONS FROM THE LOSS OF SAVINGS, FAMILY HOME OR FARM DUE TO EXCESSIVE MEDICAL COSTS. UNDER THE CURRENT LAWS, PEOPLE LIKE YOU AND I COULD BE FACED WITH FINANCIAL DEVASTATION FROM MEDICAL BILLS AS WE ARE "TOO WELL OFF TO BE ELIGIBLE FOR MEDICAID OR OTHER GOVERNMENT PLANS". THOSE OF US WHO WANT TO TAKE CARE OF OUR EARTHLY OBLIGATIONS, BUT DUE TO INCREASING MEDICAL COSTS FIND IT INCREASINGLY DIFFICULTY TO DO SO. PASSAGE OF THIS BILL WILL

GREATLY HELP THESE PEOPLE TO BE FREE FROM FINANCIAL WORRIES CAUSED BY HIGH MEDICAL COSTS AND THE UNAVAILABILITY OF MEDICAL INSURANCE TO ASSIST WITH THOSE BILLS.

ANOTHER PERSON WHO MAY FIND THEMSELVES LOOKING FOR INSURANCE AND NO PLACE TO FIND IT IS A YOUNG PERSON WHO IS NO LONGER ABLE TO REMAIN ON THE PARENTS PLAN BECAUSE OF AGE OR DEPENDENCY REASONS. SOME OF THESE YOUNG PEOPLE ARE NOT FULLY AWARE OF THE NEED FOR INSURANCE COVERAGE AND DO NOT PURCHASE A PLAN RIGHT AWAY THINKING THAT THEY ARE YOUNG AND HEALTHY AND NOTHING CAN HAPPEN TO THEM ONLY TO FIND THEMSELVES THE VICTIM OF AN ACCIDENT OR ILLNESS WHICH LEAVES THEM "UNINSURABLE". SUCH A CASE COMES TO MIND WITH A CLIENT OF MINE: THIS IS A MAN IN HIS EARLY 20S WHO WAS THE VICTIM OF A GUN SHOT WOUND IN WHICH THE MAJOR ARTERY IN HIS LEG WAS DAMAGED RESULTING IN GRAFTING OF THE ARTERY; TO DATE HE HAS UNDERGONE 15 SURGERIES, THE MOST RECENT WITHIN THE PAST 6 MONTHS AND HE WILL BE ON A BLOOD THINNING MEDICATION FOR THE REMAINDER OF HIS LIFE. THIS HUNTING ACCIDENT HAS NOT ONLY LEFT HIM UNINSURABLE, BUT DUE TO HIS UNINSURABILITY, EMPLOYERS ARE RELECTANT TO HIRE HIM AS AN EMPLOYEE, THEREFORE NO GROUP COVERAGE IS AVAILABLE EITHER.

74

IN CHECKING THE NEED FOR SUCH A PLAN TO TO IMPLEMENTED
IN THE STATE OF MONTANA OUR COMMITTEE VISITED WITH VARIOUS
ORGANIZATIONS SUCH AS DIABESTES, HEART FUND, CRIPPLED CHILDREN,
CANCER SOCIETY, MENTAL HEALTH, MUSCULAR DYSTROPHY, TO NAME A
FEW. ALL EXPRESSED A VERY REAL NEED FOR THIS TYPE OF INSURANCE
PLAN. FROM INFORMATION GAINED FROM THESE SOURCES IT IS ESTIMATED
THAT THERE COULD BE FROM 2,000 TO 5,000 PERSONS IN MONTANA
WHO WOULD BE ELIGIBLE FOR COVERAGE UNDER THIS PLAN WHO ARE
CURRENTLY NOT COVERED UNDER ANY OTHER FORM OF MEDICAL INSURANCE
COVERAGE. IT IS TRUE THAT SOME OF THESE PEOPLE ARE BORDERLINE
POVERTY AND POSSIBLY WOULD NOT BE ABLE TO AFFORD THE PREMIUMS
FOR ANY POLICY, BUT SOME OF THOSE HAVE INDICATED THEY WOULD
RATHER HAVE THE INSURANCE PROTECTION THAN CHANCE LOSING THEIR
HOME AND BE FORCED TO GO ON WELFARE OR MEDICAID - THESE ARE
PROUD PEOPLE WHO ARE RESPONSIBLE CITIZENS WHO WANT TO BE ABLE
TO TAKE CARE OF THEIR OWN OBLIGATIONS IN LIFE. THIS BILL WILL
GIVE THEM THAT CHANCE.

ADDITIONAL CHECKING AND COMPARING OF PLANS WAS DONE BY
EXAMINING SIMILAR PLANS OFFERED BY OTHER STATES.

IN SUMMARY: UNDER CURRENT INSURANCE PRACTICES IN THE INDIVIDUAL HEALTH INSURANCE MARKETS, AND IN SMALL GROUP PLANS UNDERWRITING FOR CAUSE PREVENTS MANY PERSONS FROM BEING ACCEPTED FOR MEDICAL INSURANCE COVERAGE FOR MEDICAL REASONS. BY MEANS OF THIS BILL, THOSE SAME PERSONS WOULD HAVE A PLAN OF INSURANCE AVAILABLE TO THEM.

WOULDN'T YOU AGREE THAT IT IS FAR BETTER TO OFFER A PLAN OF INSURANCE AVAILABLE TO THIS SPECIAL GROUP OF PEOPLE THAN TO HAVE THEM FINANCIALLY DEVASTATED BY MEDICAL COSTS TO THE POINT THAT THAT PERSON WOULD BE ELIGIBLE FOR MEDICAID AND WELFARE WHICH WOULD IN TURN PLACE A LARGER BURDEN ON THE STATE OF MONTANA?

THE MONTANA ASSOCIATION OF HEALTH UNDERWRITERS AND MYSELF URGE YOU TO CONSIDER THIS BILL AND VOTE FAVORABLY FOR ITS PASSAGE.



American
Diabetes
Association

MONTANA AFFILIATE, INC.

Exhibit 4
2/18/85
House Bill 817

Submitted by: Stanlee
Dau

600 Central Plaza

• Box 2411 •

Great Falls, Montana 59403

• (406) 761-0908

February, 1985

The American Diabetes Association, Montana Affiliate, and its members is pleased that the Montana Legislature is considering a bill to guarantee health insurance coverage for the citizens of the state who presently cannot obtain this protection because of current or past illness and disease.

Speaking from our own experience, there are 23,000 persons with diabetes in Montana. Most of these people are in good health, living with daily exercise regimens and an excellent diet. Yet, because they have diabetes, it is impossible for many of them to obtain health insurance coverage. It is our concern that these people will be able to purchase insurance coverage for reasons unrelated to diabetes as well, without facing financial hardship.

Our offices have received many calls from people across the state who are unable to obtain insurance coverage for themselves or their children. A family from Eureka recently called to tell us that they could not obtain health insurance for their 15 year old son even with an offer to pay the premiums one year in advance. It is a common underwriting practice to deny anyone under 35 years of age who has Type I, Juvenile, or Insulin Dependent diabetes.

It is our hope that persons with diabetes and other chronic illnesses may be able to obtain affordable health insurance coverage as a result of this legislation.

Thank you for your consideration of the needs of uninsurable citizens of Montana.

PROPOSED AMENDMENTS TO HB 817

Section 4 subsection 2 found on page 5 is amended to read as follows:

(2) Each of the seven board members representing the association members is entitled to vote, in person or by proxy, based on the association member's annual Montana premium volume, in accordance with the following schedule:

\$ 100,000 -- \$ 4,999,999	1 vote
5,000,000 -- 9,999,999	2 votes
10,000,000 -- 14,999,999	3 votes
15,000,000 or more	4 votes

page 9 Section 6 subsection 3(b)(i) found on page 9 is amended to read as follows:

(i) care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, ~~for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self insurance,~~ or for which benefits are payable under another policy of disability insurance or medicare;

Section 9 subsection 6 found on page 13 is amended to read as follows:

(6) Any annual fiscal yearend or interim assessment levied against an association member may be offset, in an amount equal to the assessment paid to the association, against the premium tax payable by that association member pursuant to 33-2-705 for the year in which the annual fiscal yearend or interim assessment is levied. The ~~department of revenue~~ insurance commissioner shall, each year the legislature meets in regular session, on or before January 15, report to the legislature the total amount of premium tax offset claimed by association members during the preceding biennium.

Exhibit 6
2/18/85
House Bill 817
February 14, 1985

Submitted by: Rep.
Kitselman

Kathy-E. Barkell
1439 Barrett Road
Billings, MT. 59105

Representative Les Kitselman
Capitol Station
Helena, MT. 59601

RE: HB 817 Pooled Risk Health Insurance Bill
Business and Labor Committee

Dear Representative Kitselman:

Please have the following letter read as testimony in favor of House Bill 817 when it comes before the Business and Labor Committee for consideration. Unfortunately, I am unable to come to Helena to testify in person.

I am the single parent of an eleven-year-old son, Ryan. In January, 1984, Ryan was diagnosed as having Juvenile Diabetes Mellitus. I am enclosing a copy of the prognosis given to me by his Doctor shortly after the diagnosis.

The financial impact of the disease is considerable at best and could be catastrophic. I am on a very fixed budget and receive no child support whatsoever from his father. On a regular basis, we must purchase insulin, syringes, blood and urine chemical testing strips and miscellaneous supplies. In addition to this, frequent visits to the Doctor and Diabetes Educator and expensive laboratory tests are necessary. The average cost is \$125.00 per month for the above necessities.

To this point, we have been extremely fortunate in that Ryan has not suffered any major complications nor required hospitalization. Even a bad case of the flu could require a hospital stay, which I have no idea how I would pay for.

I implore you to support HB 817 which would make affordable health insurance available to high risk individuals such as my son. At this time, Ryan is not covered by any health insurance, nor can I find a company that will insure him. I have contacted numerous insurance companies and have not been able to find one to cover Ryan, even as a dependent. Please note the attached example of this denial of coverage from MT. Physicians Service.

I urge the Committee to give a due pass recommendation for HB 817. It is vitally important for families and individuals to be able to acquire affordable, quality health care coverage to combat sky-rocketing medical costs and to insure that medical services will be available when needed.

Yours Truly,

Kathy - E. Barkell

THE BILLINGS CLINIC

THE BILLINGS CLINIC — HEIGHTS OFFICE

NINTH AVE NORTH AT BROADWAY
MAILING ADDRESS P.O. BOX 35100
BILLINGS, MONTANA 59107-5100
(406) 256-2500

WICKS LANE AT BABCOCK BOULEVARD
MAILING ADDRESS: P.O. BOX 35104
BILLINGS, MONTANA 59107-5104
(406) 256-2500

ALLERGY

L. Bruce Anderson Jr. M.D.

DERMATOLOGY

Thomas P. Conneely M.D.

William H. Smoot, M.D.

IMMEDIATE CARE

Osvald W. Rehrusch, M.D.

Gene V. Henden, M.D.

INTERNAL MEDICINE

Allan Lee Goulding, M.D. P.C.

George R. Brinkus, M.D.

Paul V. Hoyer, M.D.

Luinda M. Hixley, M.D.

Barry M. Hochstadt, M.D.

James J. Mullen, M.D.

OBSTETRICS

Walter E. Dwyer, M.D.

John H. Burg, M.D.

Herman D. Sorensen, M.D.

ENDOCRINOLOGY

Marion E. Kodish, M.D.

GASTROENTEROLOGY

John C. Finke, M.D.

HEMATOLOGY

Warren D. Bowman, Jr. M.D.

Wilderness and Mountain Medicine

INFECTIOUS DISEASES

Ronald H. Smith, M.D.

MEDICAL ONCOLOGY

Donald L. Twito, M.D.

NEPHROLOGY

Donald L. Hicks, M.D.

James D. Krossman, M.D.

PULMONARY AND CRITICAL CARE MEDICINE

Terrence J. Fagan, M.D.

Nicholas J. Wolter, M.D.

RHEUMATOLOGY

Philip E. Griffin, Jr. M.D.

NEUROSCIENCES

Neurology ELECTROMYOGRAPHY &

ELECTROENCEPHALOGRAPHY

Dale M. Peterson, M.D.

Patrick J. Cahill, M.D.

NEUROLOGICAL SURGERY

Robert C. Wood, M.D.

Lashman W. Sonya, M.D. P.C.

PSYCHIATRY

William H. Hagie, M.D.

PSYCHOLOGY

Robert E. Tompkins, Ed. D.

GYNECOLOGY AND GYN/OB

William H. Deschner, M.D. P.C.

Thomas C. Olson, M.D. P.C.

Mark E. Randak, M.D. P.C.

James R. Harris, M.D.

REPRODUCTIVE AND INFERTILITY

Edward F. Randak, M.D. P.C.

OPHTHALMOLOGY

James S. Good, M.D. P.C.

James H. Olson, M.D.

ORTHOPEDICS

Stefan R. Hayward, M.D.

Wilford J. Hall, M.D. P.C.

James E. Scurr, M.D. P.C.

James F. Schwartz, M.D.

Raegun M. Jensen, M.D.

OTOLARYNGOLOGY

Stephen A. Kramer, M.D.

PEDIATRICS

Allen P. Friedman, M.D.

Patrick Sauer, M.D.

Paul H. Koller, M.D.

Fred E. Gunville, M.D.

Office - Marian A. Jones, M.D.

RADIAL, THORACIC, CARDIAC AND VASCULAR SURGERY

John W. Heizer, M.D. P.C.

Q. Adrian Johnson, M.D. P.C.

Hawes D. Agnew, M.D. P.C.

Paul F. Grindley, M.D. P.C.

Robert N. Hurd, M.D.

John R. Gregory, M.D.

UROLOGY

Robert S. Hagstrom, M.D.

C. Dale Vermillion, M.D.

John J. Martin, M.D.

RADIOLOGY

Jerry D. Wolf, M.D.

V. Paul Johnson, M.D.

Bruce G. Pinkerton, M.D.

Dean A. Bruschwein, M.D.

CONSULTANTS

MEDICAL DIRECTOR

Paul V. Hoyer, M.D.

ADMINISTRATOR

William P. Nicholson

February 15, 1984

Mrs. Kathy E. Barkell
1439 Barrett Road
Billings, MT 59105

RYAN BARKELL
BC# 273321-0

Dear Mrs. Barkell:

As you well know, Ryan has developed juvenile diabetes mellitus within the last month. He is currently on insulin and is in the process of stabilization of his diabetes. Diabetes is a chronic day-to-day illness that does not go away. He will be on insulin the rest of his life. The ultimate prognosis, I think, depends on what develops in the future for treatment and management of diabetes. There is also the factor of how stable Ryan's control of his diabetes is as he gets older.

Currently, there are such new changes in diabetes in terms of portable infusion pumps and a number of other still somewhat experimental modes of treatment that hopefully as Ryan grows older his prognosis will be better than that of diabetics in the past. There are certainly always the prognostic problems of eye trouble, kidney problems and other complications of diabetes.

I hope this letter will be of some help. As I have mentioned, this is a chronic day-to-day, long-term struggle to manage and regulate diabetes.

Sincerely,



PATRICK SAUER, M.D.

GO

MONTANA PHYSICIANS' SERVICE

404 Fuller Avenue • P.O. Box 4309 • Helena, Montana 59604 • (406) 442-5450



BLUE SHIELD

Medical • Surgical • Hospital

April 27, 1984

Kathe Barkell
1439 Barrett Road
Billings, MT 59105

Group No. 02-3429
Cert. No. 343007
Effective Date: 5-1-84

Dear Ms. Barkell:

We are pleased to accept your Blue Shield membership application which will become effective as shown above.

Coverage will not, however, include your son, Ryan who our Medical Review Consultants were unable to accept for medical reasons.

Your Identification cards will be sent to you shortly. We look forward to serving you as a new member of Blue Shield.

Sincerely,

Colleen Teberg
Colleen Teberg
Service Representative
Member Accounting

cc: Group

VISITORS' REGISTER

BUSINESS AND LABOR

COMMITTEE

BILL NO. House Bill 817DATE February 18, 1985SPONSOR Representative Kitselman

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
ROBERT STEIL	CHICAGO ILL	✓	✓ <i>in person</i>
Rdy Johnson	PIA	X	
Don Allen	Helena	✓	
Rick Bach	Helena	✓	
John Allen	MPS	✓	
Willam Jern	Blue Cross	✓	
Steve Davis	^{B-111 ags} Dist. - 1st Coalition	X	
Judy Olson	MIA	✓	
James Lechner	Billings	✓	
J. Daniel	Big	✓	
Stanley Olson	Great Falls	✓	
Barbara Penner	Helena	✓	
Marilyn J. Brown	Cascade	✓	
Lynne Hansen	McLean Leg. road	✓	
Don Williams	4195 Blue Shield	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

MINUTES OF THE MEETING
BUSINESS AND LABOR COMMITTEE
MONTANA STATE
HOUSE OF REPRESENTATIVES

February 19, 1985

The meeting of the Business and Labor Committee was called to order by Chairman Bob Pavlovich, on February 19, 1985 at 7:00 a.m. in Room 312-2 of the State Capitol.

ROLL CALL: All member were present.

ACTION ON HOUSE BILL 817: Representative Brandewie made a motion that House Bill 817 DO PASS. Representative Kitselman moved the amendments and statement of intent. Representative Driscoll and Schultz raised questions regarding those high risk individuals. Representative Glaser stated residency is defined in the election laws. Question being call, the amendments and statement of intent DO PASS by a unanimous vote. House Bill 817 DO PASS AS AMENDED WITH STATEMENT OF INTENT unanimously.

ACTION ON HOUSE BILL 668: Representative Kilselman moved to TABLE House Bill 668. He explained that this will create "stripping" of group insurance policies. House Bill 668 was TABLED unanimously.

ACTION ON HOUSE BILL 554: Representative Thomas moved DO PASS on House Bill 554. Representative Thomas then moved and explained the amendments to the bill which do not include prevailing wage. The amendments do pass by unanimous vote. House Bill 554 DO PASS AS AMENDED unanimously.

ACTION ON HOUSE BILL 773: Representative Kadas moved DO PASS on House Bill 773. Representative Kadas proposed an amendment to eliminate "stripper wells" from the bill. Representative Kitselman added that oil purchases have to be accounted for and there is little theft. Representative Keller stated that royalty owners will not benefit. Representative Kadas then withdrew his motion. A "stripper well" is one that produces less than 10 barrels per day. Representative Driscoll moved that a provision in section 1 be added to not apply to "stripper wells". Said amendments did pass by a unanimous vote. Representative Kitselman made a substitute motion that House Bill 773 be TABLED, which received a unanimous vote.

ACTION ON HOUSE BILL 634: Representative Thomas made a motion that House Bill 634 DO PASS. Second was received, House Bill 634 DO PASS by unanimous vote.

DAILY ROLL CALL
BUSINESS AND LABOR COMMITTEE

49th LEGISLATIVE SESSION -- 1985

Date February 19, 1985

NAME	PRESENT	ABSENT	EXCUSED
Bob Pavlovich	✓		
Les Kitselman	✓		
Bob Bachini	✓		
Ray Brandewie	✓		
Jan Brown	✓		
Jerry Driscoll	✓		
Robert Ellerd	✓		
William Glaser	✓		
Stella Jean Hansen	✓		
Marjorie Hart	✓		
Ramona Howe	✓		
Tom Jones	✓		
Mike Kadas	✓		
Vernon Keller	✓		
Lloyd McCormich	✓		
Jerry Nisbet	✓		
James Schultz	✓		
Bruce Simon	✓		
Fred Thomas	✓		
Norm Wallin	✓		

STANDING COMMITTEE REPORT

February 19

85

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page 1 of 3

SPEAKER

MR.

BUSINESS AND LABOR

We, your committee on

HOUSE

having had under consideration Bill No. 817

FIRST

WHITE

reading copy (color)

HEALTH INSURANCE POOLING ACT

HOUSE

817

Respectfully report as follows: That Bill No.

BE AMENDED AS FOLLOWS:

- 1) Page 2, line 1
Following: "state" "and"
Strike: the remainder of line 1, line 2 in its entirety, and
line 3 through "application"
Insert: " applies"
- 2) Page 3, line 2
Following: "means"
Strike: the remainder of line 2, lines 3 and 4 in their entirety
and line 5 through "benefits"
Insert: "any plan, program, contract, or other arrangement to the
extent not exempt from inclusion by virtue of the provisions
of the Federal Employee Retirement Income Security Act under
which one or more employers, unions, or other organizations
provide to their employees or members, either directly or
indirectly through a trust or a third party administrator,
health care services or benefits other than through an
insurer."

DO PASS

- 3) Page 4, line 4
Following: "a"
Insert: "nonprofit legal entity to be known as the Montana"
- 4) Page 5, line 20
Following: "to"
Insert: "a weighted average"
- 5) Page 5, line 21
Following: "annual"
Insert: "Montana"
- 6) Page 5, line 22
Following: "volume"
Strike: ", "
Insert: ". "
Strike: the remainder of line 22, lines 23, 24 and 25 and line 1 on page 6, in their entirety
- 7) Page 6, line 16
Following: "22"
Insert: "excepting part 7,"
- 8) Page 8, line 1
Following: "dental;"
Insert: "and"
- 9) Page 8, line 3
Following: "year"
Strike: the remainder of line 3, line 4 in its entirety, and line 5 through "33-22-703"
- 10) Page 9, line 3
Following: "law,"
Strike: the remainder of line 3, lines 4, 5 and 6 in their entirety, and line 7 through "~~self-insurance,~~" "or"
- 11) Page 9, line 22
Following: "transplants"
Strike: the remainder of line 22 and line 23 through "association"
- 12) Page 11, line 11
Following: "necessary. The"
Strike: "commissioner"
Insert: "association"

HB817

page 3 of 3

- 13) Page 11, line 18
Strike: "908"
Insert: "888"
- 14) Page 11, line 20
Strike: "108"
Insert: "128"
- 15) Page 13, line 23
Following: "The"
Strike: the remainder of line 23 and line 24 through "revenue"
Insert: "insurance commissioner"
- 16) Page 16, line 17
Following: "12,"
Strike: "XX agent of"
Insert: "XX independent contractor for"
- 17) Page 16, line 18
Following: "is"
Strike: "civilly"
Insert: "individually"
- 18) Page 18, line 13
Following: "effective"
Strike: the remainder of line 13, lines 14 and 15 in their entirety and line 16 through "12."
Insert: "on the first of the month following acceptance"
- 19) Page 19, line 4
Following: line 3
Insert: "(5) A change of residence from Montana to another state immediately terminates eligibility for renewal of coverage under the association plan."

NEW SECTION. Section 13. Liability of association membership. No member of the association is liable for the actions of the association or its lead carrier."

Renumber: subsequent sections

- 20) Page 19, line 9
Strike: "12"
Insert: "13"
- 21) Page 19, line 11
Strike: "12"
Insert: "13"

STATEMENT OF INTENT

A statement of intent is required for this bill because it grants rulemaking authority to the commissioner of insurance for the purpose of making effective the provisions and purposes of this act.

The purpose of this act is to establish a mechanism through which adequate levels of health insurance coverages can be made available to residents of this state who are otherwise considered uninsurable. This bill establishes a state association or pool of which all insurers, health service corporations, and fraternal benefit societies providing health care benefits in Montana are members.

It is intended that the pool coverage is the coverage of "last resort" and is not intended to duplicate coverages from any other source, private or public. The mechanics of the pool and its operations and functions must all be established under a plan approved by the commissioner. The pool is subject to the requirements of the insurance code and has the general powers and authority of an insurer licensed to transact health insurance business in this state.

It is intended that the association board of directors be responsible for the day-to-day operations of the association, subject to the review and approval of the insurance commissioner.

CHAIRMAN--JACOBSON, JUDY
NORMAL SCHEDULE==> SITE: ROOM 410

DAYS: M-W-F

TIME: 12:30-2:30 P.M.

SECRETARY-GRAVELEY, ELAINE

--BILL NO--	REFER DATE	HEARING DATE	CONSIDERATION DATES	COMMITTEE ACTION	REREFERRED TO COMM	DATE OUT
HB0807	3/04	3/11	3/13 3/23			
HANNAH, TOM			PROTECTION OF CHILDREN BY REQUIRING MEDICAL TREATMENT BE PROVIDED			
HB0817	3/04	3/11	3/13	CONCUR AS AMENDED		3-13
KITSELMAN, LES			HEALTH INSURANCE POOLING ACT			
HB0843	4/03	4/09	4/15	CONCUR AS AMENDED		4-15
HOUSE APPROPRIATIONS COMM.			GENERALLY REVISE LAWS RELATING TO GENERAL ASSISTANCE			
HB0896	3/05	3/25		CONCUR AS AMENDED		3-25
IVERSON, DENNIS			DEFINING PERMISSIBLE FIREWORKS & FURTHER REGULATING THEIR SALE AND USE			
HJ0006	1/18	1/23		CONCUR		1-23
BROWN, JAN			OPPOSITION TO PERSECUTION OF BAHAI'S IN IRAN			
HJ0019	2/08	3/25	3/27	CONCUR		3-27
WALDRON, STEVE			URGING PRIORITY REFERRAL AND PLACEMENT FOR PREGNANT TEENAGERS			

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MINUTES OF THE MEETING
PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE
MONTANA STATE SENATE

MARCH 11, 1985

The meeting of the Public Health, Welfare and Safety Committee was called to order by Chairman Judy Jacobson on Monday, March 8, 1985 in Room 410 of the State Capitol at 12:30.

ROLL CALL: All members were present. However, Senators Towe and Newman arrived late. Karen Renne, staff researcher, was also present.

There were many, many visitors in attendance. See attachments.

CONSIDERATION OF HOUSE BILL 114: Representative Joan Miles of House District 45 in Helena, the sponsor of HB 114, gave a brief resume of the bill. This bill was requested by the Department of Health and Environmental Sciences. HB 114 is an act to generally revise and clarify the laws relating to swimming pools and bathing places; clarifying that the Department of Health and Environmental Sciences may set safety standards for public swimming pools and bathing places; and providing an immediate effective date.

Representative Miles handed out copies of the existing laws. See attachments. This same bill was introduced last session. The laws need to address the safety measures. There seems to be some confusion regarding "safety" in some places in the codes.

Sam Murfitt, representing the Montana Department of Health and Environmental Sciences, stood in support of the bill. Mr. Murfitt stated that safety has always been a major portion of a total swimming pool program throughout the nation. In Montana, safety has been a major portion of the swimming pool program since 1967 when the present law was passed. The law was written with safety included in some sections and not in others. In those sections where the terms "safety" or "safe" were not used, the term "to protect the public health" was substituted. Mr. Murfitt handed in written testimony for the record. See attachments.

With no further proponents, the chairman called on the opponents. Hearing none, the meeting was opened to a question and answer period from the Committee.

Senator Hims1 asked if there is a need for this bill. Mr. Murfitt replied that there is a definite need for this legislation.

4

SENATE PUBLIC HEALTH
PAGE FOUR
MARCH 11, 19855

Senator Towe asked Mrs. Skoogs about patients being able to refuse treatment. She stated that her group wants to know that they are free of all liability when a patient refuses treatment of any kind.

Senator Towe asked Mr. Blakely about the door being able to be closed. Mrs. Skoogs stated that this interferes with the facility's ability to take care of its patients and will lead to such absurd practices as knocking on patients' doors and waking them in the middle of the night while doing room checks. In addition, it is impossible to provide an absolute right to each resident to have the door of his room closed if his medical condition allows it, since that does not take into account the medical attention needed by the patient's roommate. Most nursing home patients are in rooms with at least one other person, some are even in four bed wards.

Senator Stephens asked about the 30 days advance written notice of any transfer or discharge. Mrs. Skoogs stated that HB 783 adds the language that reasonable advance notice requires at least 30 days in advance written notice of any interfacility transfer or any discharge, except in the case of emergency as documented by the resident's attending physician in his medical record. This language is too restrictive and is arbitrary. There may be circumstances where 5 days is reasonable and others when significantly more than 30 days required.

Representative Miles closed. She stated that this new language has been adopted by 30 other states. The nursing homes amendments were rejected in the hearing in the House.

CONSIDERATION OF HOUSE BILL 817: Representative Les Kitselman of Billings, the chief sponsor of House Bill 817, gave a brief resume of the bill. This bill is an act to provide health insurance coverage to certain persons ineligible for coverage from traditional providers of health care benefits by establishing a Montana Comprehensive Health Association and Plan; to require participation in the Association by each health service corporation, fraternal benefit society; and insurer providing health care benefits in this state; and providing effective dates.

Representative Kitselman handed out some proposed amendments which he felt would make the bill more workable and make for a better bill.

604

SENATE PUBLIC HEALTH
PAGE FIVE
MARCH 11, 1985

He read a part of a letter from a young single mother in Billings. "I am a single parent of an eleven year old son. In January of 1984, he was diagnosed as having Juvenile Diabetes. The financial impact of the disease is considerable at best and could be catastrophic. I am on a fixed budget and receive no child support whatsoever from his father. An average cost per month for necessities for him is \$125. Even a bad case of the flu could require a hospital stay, which I have no idea how I would pay for. Please support HB 817 which would make affordable health insurance available to high risk individuals such as my son. At this point my son is not covered by any health insurance, nor can I find a company that will insure him. I have contacted numerous insurance companies and have not been able to find one that will cover my son, even as a dependent."

Marie Deonier, representing the Montana Association of Health Underwriters, stood in support of the bill. She handed in written testimony to the members of the Committee. See attachments.

Stanlee Dull, executive director of the American Diabetes Association, stood in support of the bill. She handed in written testimony to the Committee for their consideration. See attachments. She also handed in a letter from Marilyn Moore, President of the Montana affiliate of the American Diabetes Association. See attachments.

Elmer Hauken, Montana Association of Life Underwriters, stood in support of the bill as amended. He stated that this is a very necessary bill and one that will not cost the state any money.

Chuck Elke, representing the Montana Physician Service, stood in support of the bill.

Barbara Penner, representing the Montana Heart Association, stood in support of the bill.

Wade Wilkinson, representing the Low Income Senior Citizens Association, stood in support of the concept of the bill. He stated that this is a very positive measure.

Don Allen, representing the Montana Hospital Association, stood in support of the bill.

Jerry Loendorf, representing the Montana Medical Association, stood in support of the bill.

SENATE PUBLIC HEALTH
PAGE SIX
MARCH 11, 1985

Tanya Ask, representing the Montana Audit Department, stood in support of the bill as amended.

Tom Hager, representing himself as a consumer, stood in support of the bill. He stated that everyone needs a health plan which would take care of them. This is a very necessary bill.

With no further proponents, the chairman called on the opponents. Hearing none, the meeting was opened to a question and answer period from the Committee.

Senator Hims1 asked why would people loose their insurance if they moved from the state under this bill. Representative Kitselman stated that since some other nearby states do not have a policy as this, he is concerned that people who live elsewhere would come to Montana and buy the insurance and then move away.

Senator Hims1 asked if the cost is known at this time. The cost is unknown at this time, however, it would be like automobile insurance with a share in the coverage and also in the premium. A regulatory board will set up the costs.

Senator Towe asked if this is modeled after the insurance program of another state. It is modeled somewhat after the 1980 North Dakota Insurance program.

Senator Towe asked if one can just go buy this insurance. No, you must be denied coverage by two insurance companies before qualifying for this plan.

Representative Kitselman closed.

CONSIDERATION OF HOUSE BILL 649: Representative Jack Moore of Great Falls, the chief sponsor of House Bill 649, gave a brief resume of the bill. This bill was requested by the Department of Commerce. HB 649 is an act revising for administrative purposes the laws relating to regulation of the practice of denturity.

This is a compromise bill between the dentist and the denturists of Montana. This bill will come under sunset review in two years.

PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE

49th LEGISLATIVE SESSION -- 1985

Date 3/11/85SENATE
SEAT

#

	NAME	PRESENT	ABSENT	EXCUSED
6	SENATOR JUDY JACOBSON, CHAIRMAN	✓		
5	SENATOR J. D. LYNCH, V. CHAIRMAN	✓		
42	SENATOR TOM HAGER	✓		
30	SENATOR MATT HIMSL	✓		
17	SENATOR TED NEWMAN	<i>Late</i>		
45	SENATOR BILL NORMAN	✓		
14	SENATOR STAN STEPHENS	✓		
26	SENATOR TOM TOWE	<i>Late</i>		

Each day attach to minutes.

COMMITTEE ON _____

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One	
			Support	Oppose
TEO BELL	MY SER	649	X	
SAM MURPHY	Mint. Dept 14th	114	X	
Ellie Parker	"	114	X	
B. J. Greany	Board of Dentistry	114		X
Brian Ruckman	American Diabetes Assoc	817	X	
Joe Upshaw	AMASSW ^{for LEADER LEGISLATION} Retired People	649	X	
Joe Upshaw	" "	783	X	
Tom Ryan	M. S. C. A.	649	✓	
Tom Ryan	Bill of Rights	783	✓	
E. Reilly	M. S. C. A.	649	X	
E. Reilly	M. S. C. A.	783	X	
Norma Harris	SIRS	807 783	X	
John Mober	SIRS	540	X	
Charles Briff	Governor's Office	HB 783 HB 649	X	
Mona Jamison	"	HB 649	X	
Molly Murray	MONTANA	HB 783	X	
Mona Jamison	Commerce	HB 649	X	
Bruce Buer	Self	HB 649	✓	
Joe Skoon	Montana Health Care Assn.	HB 783	Amend	
Joe Skoon	Assembly of Physicians	HB 807	✓	
Leann T. Leland	Int. Rural Assn	HB 817	✓	
D. Flavel	St. Outwardman	HB 783	Y	
Joe L. Leland	MEA	HB 840	✓	
James Hansen	MALU	HB 817	✓	
Tom Mulhoney	MBS Blue Shield	HB 817	✓	

COMMITTEE ON _____

NAME _____

REPRESENTING

BILL #

Check One

Support	Oppose
---------	--------

Barbara Penner

MT Heart Assoc.

HB 817

✓

LEE WISER

BOARD OF DENTURITRY

HB 649

✓

Sam Regan

MSCR:

✓

Jeanette S Buchanan

MT Board of Dentistry

HB 649

William NAEDEL

ST Dept of Health

HB 649

Shirley Miller

Dept of Commerce

H B649

No addition

[Handwritten signature]

Montana Ave. N.Y.C.

HB 817

1. 10/1/1960

[Handwritten signature]

Mr. Howard H. Hines

Hilf

✓

John L. ...

STATE BIRTH AD-MEMO

NR-649

✓

NAME: Marie Deonier DATE: 3/1/85

ADDRESS: 48 Shadow Place, Billings, MT 59102

PHONE: 245-7063 (res) 652-5240 (bus)

REPRESENTING WHOM? Montana Association of Health Underwriters

APPEARING ON WHICH PROPOSAL: HB 817

DO YOU: SUPPORT? X AMEND? OPPOSE?

COMMENTS: Copy of testimony to be
distributed.

We also approve & recommend the
adoption of the amendment submitted
Les Kitzelman.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

PROPOSED AMENDMENTS TO HB 817

1. Title, line 11.
Following: line 10
Insert: "INSURANCE ARRANGEMENT,"
2. Page 2, line 18.
Following: line 17
Insert: "(6) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal employee retirement income security act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust or a third party administrator, health care services or benefits other than through an insurer."
m Renumber: subsequent subsections
3. Page 3, lines 7 through 14.
Following: "benefits" in line 7
Strike: remainder of line 7 through "INSURER" in line 14
Insert: "those health benefit plans certified by the commissioner as providing the minimum benefits required by [section 6] or the actuarial equivalent of those benefits"
4. Page 4, line 16.
Following: "insurers,"
Insert: "insurance arrangements,"



American Diabetes Association

MONTANA AFFILIATE, INC.

600 Central Plaza

• Box 2411

• Great Falls, Montana 59403

• (406) 761-0908

March 11, 1985

REPRESENTATIVE
The American Diabetes Association, Montana Affiliate, and its members is pleased that the Montana Legislature is considering a bill to guarantee health insurance coverage for the citizens of the state who presently cannot obtain this protection because of current or past illness and disease.

COMMITTEE
Speaking from our own experience, there are 23,000 persons with diabetes in Montana. Most of these people are in good health, living with daily exercise regimens and an excellent diet. Yet, because they have diabetes, it is impossible for many of them to obtain health insurance coverage. It is our concern that these people will be able to purchase insurance coverage for reasons unrelated to diabetes as well, without facing financial hardship.

Our offices have received many calls from people across the state who are unable to obtain insurance coverage for themselves or their children. A family from Eureka recently called to tell us that they could not obtain health insurance for their 15 year old son even with an offer to pay the premiums one year in advance. It is a common underwriting practice to deny anyone under 35 years of age who has Type I, Juvenile, or Insulin Dependent diabetes.

It is our hope that persons with diabetes and other chronic illnesses may be able to obtain affordable health insurance coverage as a result of this legislation.

Thank you for your consideration of the needs of uninsurable citizens of Montana.

Sincerely,

Stanlee Dull
Stanlee Dull
Executive Director

bz

52

NAME: Stanlee Dull

DATE: 3-11-85

ADDRESS: 125 13th Ave So

PHONE: 761-8970 (H) 761-0908 (Office)

REPRESENTING WHOM? American Diabetes Assn.

APPEARING ON WHICH PROPOSAL: *HB 517*

DO YOU: SUPPORT? yes AMEND? _____ OPPOSE? _____

COMMENTS :

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.



American
Diabetes
Association

MONTANA AFFILIATE, INC.

600 Central Plaza

• Box 2411

• Great Falls, Montana 59403

• (406) 761-0908

POOLED RISK HEALTH INSURANCE PLAN

I believe that we should seriously consider this concept. Many people find themselves unable to purchase health insurance due to chronic medical conditions. If we want these individuals to be a productive members of our state then we, the people of the State of Montana, must be willing to make available some type of a health insurance program. Often persons who find themselves in this situation are willing to pay higher premiums but find coverage not available

Most persons can often control their chronic illness but they also need insurance to cover other illnesses or accidents to prevent possible bankruptcy or welfare due to unpaid medical bills.

I would appreciate your consideration on HB 817.

Marilyn F. Moore
President
Montana Affiliate, A.D.A.

MINUTES OF THE MEETING
PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE
MONTANA STATE SENATE

MARCH 13, 1985

The meeting of the Senate Public Health, Welfare and Safety Committee was called to order by chairman, Judy Jacobson on Wednesday, March 13, 1985 in Room 410 of the State Capitol at 12:30 p.m.

ROLL CALL: All members were present with the exception of Senator Lynch who arrived late. Karen Renne, staff researcher was also present.

There were many, many people in attendance. See attachments.

CONSIDERATION OF HOUSE BILL 720: Representative Jan Brown of Helena, the chief sponsor of HB 720, gave a brief resume of the bill. This bill is an act to establish an office of long-term care ombudsman within the office of the governor, to specify the powers and duties of the ombudsman; to impose certain requirements on long-term care facilities; to provide for access to and confidentiality of records; and providing an effective date.

Doug Blakely, the state ombudsman from the governor's office, stood in support of the bill. He stated that the ombudsman bill covers the operation of two advocacy programs for senior citizens, the Long-term Care Ombudsman Program and the Elderly Legal Services Developer Program. The program is currently administratively attached to the Governor's Office. Financial monitoring and overall grant monitoring is done by SRS, since they receive the federal funds for the program. Daily supervision is provided by the Board of Visitors, which is also attached to the Governor's Office. Basic duties include investigation and resolving complaints on the health, safety, welfare and rights of residents as well as cases of elder abuse, neglect or exploitation pertaining to long-term care residents; monitoring legislation, laws effecting long-term care residents; providing information to public agencies on long-term care issues; and promoting the development of citizen organizations in long-term care facilities. Mr. Blakely handed out fact sheets to the members of the Committee for their consideration. See attachments.

Molly Munro, Executive Secretary for the Montana Association of Homes for the Aging, stood in support of the bill. She stated that this bill provides that the office of long-term care ombudsman be placed in the Governor's office to give it greater autonomy. This is most necessary. Mrs. Munro handed in testimony for the Committee to consider. See attachments.

SENATE PUBLIC HEALTH
PAGE ELEVEN
MARCH 13, 1985

DISCUSSION ON HOUSE BILL 738: This bill is sponsored by Representative Kelly Addy, regarding the Medical Legal Panel.

Senator Hims1 asked that the Committee pass consideration for the day as they were not ready to act on this bill.

ACTION ON HOUSE BILL 817: Representative Les Kitselman of Billings is the chief sponsor of HB 817 which is an act to provide health insurance coverage to certain persons ineligible for coverage from traditional providers of health care benefits by establishing a Montana Comprehensive Health Association and Plan; to require participation in the Association by each health service corporation, fraternal benefit society, and insurer providing health care benefits in this state; and providing effective dates.

A motion was made by Senator Hager to adopt the proposed amendments of the sponsor of the bill. Motion carried.

A motion was made by Senator Hager that HB 817 BE CONCURRED IN AS AMENDED. Motion carried. Senator Hager will carry this bill on the floor of the Senate.

ANNOUNCEMENTS: The next meeting of the Senate Public Health, Welfare and Safety Committee will be held on Friday, March 15, 1985 in Room 410 of the State Capitol to discuss HB 280, 358, 487, 623, and 646.

ADJOURN: With no further business the meeting was adjourned.


SENATOR JUDY JACOBSON, CHAIRMAN

eg

ROLL CALL

PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE

49th LEGISLATIVE SESSION -- 1985

Date 3/12/85

DATE
AT

NAME	PRESENT	ABSENT	EXCUSED
SENATOR JUDY JACOBSON, CHAIRMAN	✓		
SENATOR J. D. LYNCH, V. CHAIRMAN	<i>Late</i>		
SENATOR TOM HAGER	✓		
SENATOR MATT HIMSL	✓		
SENATOR TED NEWMAN	✓		
SENATOR BILL NORMAN	✓		
SENATOR STAN STEPHENS	✓		
SENATOR TOM TOWE	✓		

Each day attach to minutes.

SENATE

STANDING COMMITTEE REPORT

MARCH 13, 1985

MR. PRESIDENT

We, your committee on PUBLIC HEALTH, WELFARE AND SAFETY

having had under consideration HOUSE BILL No. 817

THIRD reading copy (BLUE)
color

HEALTH INSURANCE POOLING ACT

KITSELMAN (HAGER)

Respectfully report as follows: That HOUSE BILL No. 817

be amended as follows:

1. Title, line 11.

Following: line 10.

Insert: "INSURANCE ARRANGEMENT,"

2. Page 2, line 18.

Following: line 17.

Insert: "(6) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal employee retirement income security act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust of a third party administrator, health care services or benefits other than through an insurer."

Renumber: subsequent subsections

3. Page 3, lines 7 through 14.

Following: "benefits" in line 7.

Strike: remainder of line 7 through line 14.

Insert: "those health benefit plans certified by the commissioner as providing the minimum benefits required by [section 6] or the actuarial equivalent of those benefits."

4. Page 4, line 16.

Following: "insurers,"

Insert: "insurance arrangements,"

~~XXXXXX~~

~~XXXXXXXXXX~~

AND AS AMENDED
BE CONCURRED IN

Judy Jacobson
SENATOR JUDY JACOBSON Chairman.

58

1 STATEMENT OF INTENT

2 HOUSE BILL NO. 817

3 House Business and Labor Committee
4

5 A statement of intent is required for this bill because
6 it grants rulemaking authority to the commissioner of
7 insurance for the purpose of making effective the provisions
8 and purposes of this act.

9 The purpose of this act is to establish a mechanism
10 through which adequate levels of health insurance coverages
11 can be made available to residents of this state who are
12 otherwise considered uninsurable. This bill establishes a
13 state association or pool of which all insurers, health
14 service corporations, and fraternal benefit societies
15 providing health care benefits in Montana are members.

16 It is intended that the pool coverage is the coverage
17 of "last resort" and is not intended to duplicate coverages
18 from any other source, private or public. The mechanics of
19 the pool and its operations and functions must all be
20 established under a plan approved by the commissioner. The
21 pool is subject to the requirements of the insurance code
22 and has the general powers and authority of an insurer
23 licensed to transact health insurance business in this
24 state.

25 It is intended that the association board of directors

1 be responsible for the day-to-day operations of the
2 association, subject to the review and approval of the
3 insurance commissioner.

52

HOUSE BILL NO. 817

INTRODUCED BY KITSELMAN, ECK, JACOBSON, WINSLOW,
HAGER, KENNERLY, THOMAS, GOULD, BERGENE, GILBERT

A BILL FOR AN ACT ENTITLED: "AN ACT TO PROVIDE HEALTH
INSURANCE COVERAGE TO CERTAIN PERSONS INELIGIBLE FOR
COVERAGE FROM TRADITIONAL PROVIDERS OF HEALTH CARE BENEFITS
BY ESTABLISHING A MONTANA COMPREHENSIVE HEALTH ASSOCIATION
AND PLAN; TO REQUIRE PARTICIPATION IN THE ASSOCIATION BY
EACH HEALTH SERVICE CORPORATION, FRATERNAL BENEFIT SOCIETY,
INSURANCE ARRANGEMENT, AND INSURER PROVIDING HEALTH CARE
BENEFITS IN THIS STATE; AND PROVIDING EFFECTIVE DATES."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Definitions. As used in [sections 1 through
12 13], the following definitions apply:

(1) "Association" means the comprehensive health
association created by [section 3].

(2) "Association plan" means a policy of insurance
coverage offered by the association through the lead
carrier.

(3) "Association plan premium" means the charge
determined pursuant to [section 8] for membership in the
association plan based on the benefits provided in [section
6].

(4) "Eligible person" means an individual who:

(a) is a resident of this state and ~~has--been-a~~
~~resident--for--at--least--1--year--immediately--preceding~~
application APPLIES for coverage under the association plan;
and

(b) within 6 months prior to the date of application,
has been rejected for disability insurance or health service
benefits by at least two insurers, societies, or health
service corporations, or has had a restrictive rider or
preexisting conditions limitation, which limitation is
required by at least two insurers, societies, or health
service corporations, which has the effect of substantially
reducing coverage from that received by a person considered
a standard risk.

(5) "Health service corporation" means a corporation
operating pursuant to Title 33, chapter 30, and offering or
selling contracts of disability insurance.

(6) "INSURANCE ARRANGEMENT" MEANS ANY PLAN, PROGRAM,
CONTRACT, OR OTHER ARRANGEMENT TO THE EXTENT NOT EXEMPT FROM
INCLUSION BY VIRTUE OF THE PROVISIONS OF THE FEDERAL
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 UNDER WHICH
ONE OR MORE EMPLOYERS, UNIONS, OR OTHER ORGANIZATIONS
PROVIDE TO THEIR EMPLOYEES OR MEMBERS, EITHER DIRECTLY OR
INDIRECTLY THROUGH A TRUST OF A THIRD-PARTY ADMINISTRATOR,
HEALTH CARE SERVICES OR BENEFITS OTHER THAN THROUGH AN

1 INSURER.

2 ~~†6†~~(7) "Insurer" means a company operating pursuant to
3 Title 33, chapter 2 or 3, and offering or selling policies
4 or contracts of disability insurance, as provided in Title
5 33, chapter 22.

6 ~~†7†~~(8) "Lead carrier" means the licensed administrator
7 or insurer selected by the association to administer the
8 association plan.

9 ~~†8†~~(9) "Preexisting condition" means any condition for
10 which an applicant for coverage under the association plan
11 has received medical attention during the 5 years
12 immediately preceding the filing of an application.

13 ~~†9†~~(10) "Qualified plan" means ~~those--health--benefit~~
14 ~~plans-certified-by-the-commissioner-as-providing-the-minimum~~
15 ~~benefits-required-by-{section-6}-or-the-actuarial-equivalent~~
16 ~~of--those--benefits ANY--PLAN--PROGRAM--CONTRACT--OR-OTHER~~
17 ~~ARRANGEMENT-TO-THE-EXTENT--NOT--EXEMPT--FROM--INCLUSION--BY~~
18 ~~VIRTUE--OF-THE-PROVISIONS-OF-THE-FEDERAL-EMPLOYEE-RETIREMENT~~
19 ~~INCOME--SECURITY--ACT--OF--1974--UNDER--WHICH--ONE--OR--MORE~~
20 ~~EMPLOYERS--UNIONS--OR-OTHER-ORGANIZATIONS-PROVIDE-TO-THEIR~~
21 ~~EMPLOYEES-OR-MEMBERS--EITHER-DIRECTLY-OR-INDIRECTLY--THROUGH~~
22 ~~A-TRUST-OR-A-THIRD-PARTY-ADMINISTRATOR--HEALTH-CARE-SERVICES~~
23 ~~OR--BENEFITS--OTHER--THAN--THROUGH--AN-INSURER- THOSE HEALTH~~
24 ~~BENEFIT PLANS CERTIFIED BY THE COMMISSIONER AS PROVIDING THE~~
25 ~~MINIMUM BENEFITS REQUIRED BY SECTION 6 OR THE ACTUARIAL~~

1 EQUIVALENT OF THOSE BENEFITS.

2 ~~†10†~~(11) "Society" means a fraternal benefit society
3 operating pursuant to Title 33, chapter 7, and offering or
4 selling certificates of disability insurance.

5 Section 2. Duties of the commissioner -- rules. The
6 commissioner shall:

7 (1) adopt rules to carry out the provisions and
8 purposes of [sections 1 through ~~†2~~ 13];

9 (2) supervise the creation of the association within
10 the limits described in [section 3];

11 (3) approve the selection of the lead carrier by the
12 association and approve the association's contract with the
13 lead carrier, including the association plan coverage and
14 premiums to be charged;

15 (4) conduct periodic audits to assure the general
16 accuracy of the financial data submitted by the lead carrier
17 and the association; and

18 (5) undertake, directly or through contracts with
19 other persons, studies or demonstration projects to develop
20 awareness of the benefits of [sections 1 through ~~†2~~ 13] so
21 that the residents of this state may best avail themselves
22 of the health care benefits provided by [sections 1 through
23 ~~†2~~ 13].

24 Section 3. Comprehensive health association --
25 mandatory membership. (1) There is established a NONPROFIT

LEGAL ENTITY TO BE KNOWN AS THE MONTANA comprehensive health association with participating membership consisting of all insurers, INSURANCE ARRANGEMENTS, societies, and health service corporations licensed or authorized to do business in this state. The association is exempt from taxation under the laws of this state, and all property owned by the association is exempt from taxation.

(2) All participating members shall maintain their membership in the association as a condition for writing health care benefits policies or contracts in this state. The association shall submit its articles, bylaws, and operating rules to the commissioner for approval.

(3) The association may:

(a) exercise the powers granted to insurers under the laws of this state;

(b) sue or be sued;

(c) enter into contracts with insurers, administrators, similar associations in other states, or other persons for the performance of administrative functions;

(d) establish administrative and accounting procedures for the operation of the association;

(e) provide for the reinsuring of risks incurred as a result of issuing the coverages required by members of the association; and

(f) provide for the administration by the association of policies that are reinsured pursuant to subsection (3)(e).

Section 4. Association board of directors -- organization. (1) There is a board of directors of the association, consisting of eight individuals:

(a) one from each of the seven participating members of the association with the highest annual premium volume of disability insurance contracts or health service corporation contracts, derived from or on behalf of residents in the previous calendar year, as determined by the commissioner; and

(b) a member at large, appointed by the commissioner to represent the public interest, who shall serve in an advisory capacity only.

(2) Each of the seven board members representing the association members is entitled to A WEIGHTED AVERAGE vote, in person or by proxy, based on the association member's annual MONTANA premium volume, ~~in accordance with the following schedule:~~

\$---100,000---	\$-4,999,999-----	1-vote-
--5,000,000-----	-9,999,999-----	2-votes
-10,000,000-----	-14,999,999-----	3-votes
-15,000,000-or-more-----		4-votes

(3) Members of the board may be reimbursed from the

money of the association for expenses incurred by them due to their service as board members but may not otherwise be compensated by the association for their services. The costs of conducting the meetings of the association and its board of directors must be borne by participating members of the association in accordance with [section 9].

Section 5. Minimum benefits of association plan. The association through the association plan shall offer a policy that provides at least the benefits of a qualified plan as required by [section 6].

Section 6. Qualified plan -- minimum benefits. A plan of health coverage must be certified as a qualified plan if it otherwise meets the requirements of Title 33, chapters 15, 22 EXCEPTING PART 7, and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

(1) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least 80% of the covered expenses required by this section in excess of an annual deductible that does not exceed \$1,000 per person. The coverage must include a limitation of \$5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but such maximums may not be less than \$100,000.

(2) Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician or other licensed health care professional provided for in 33-22-111:

(a) hospital services;

(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;

(c) use of radium or other radioactive materials;

(d) oxygen;

(e) anesthetics;

(f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3);

(g) services of a physical therapist;

(h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;

(i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;

(j) rental or purchase of medical equipment, which shall be reimbursed after the deductible has been met at the rate of 50%, up to a maximum of \$1,000;

(k) prosthetics, other than dental; AND

(l) services of a licensed home health agency, up to a

1 maximum of 180 visits per year, and

2 ~~{m}--necessary--care--and--treatment--of--mental--illness,~~
3 ~~alcoholism, and drug addiction, as provided in 33-22-703.~~

4 (3) (a) Covered expenses for the services or articles
5 specified in this section do not include:

6 (i) drugs requiring a physician's prescription;

7 (ii) services of a nursing home;

8 (iii) home and office calls, except as specifically
9 provided in subsection (2);

10 (iv) rental or purchase of durable medical equipment,
11 except as specifically provided in subsection (2);

12 (v) the first \$20 of diagnostic x-ray and laboratory
13 charges in each 14-day period;

14 (vi) oral surgery, except as specifically provided in
15 subsection (2);

16 (vii) that part of a charge for services or articles
17 which exceeds the prevailing charge in the locality where
18 the service is provided; or

19 (viii) care that is primarily for custodial or
20 domiciliary purposes which would not qualify as eligible
21 services under medicare.

22 (b) Covered expenses for the services or articles
23 specified in this section do not include charges for:

24 (i) care or for any injury or disease either arising
25 out of an injury in the course of employment and subject to

1 a workers' compensation or similar law, for which benefits
2 are payable without regard to fault under coverage
3 statutorily required to be contained in any motor vehicle or
4 other liability insurance policy or equivalent
5 self-insurance, or for which benefits are payable under
6 another policy of disability insurance or medicare;

7 (ii) treatment for cosmetic purposes other than surgery
8 for the repair or treatment of an injury or congenital
9 bodily defect to restore normal bodily functions;

10 (iii) travel other than transportation provided by a
11 licensed ambulance service to the nearest facility qualified
12 to treat the condition;

13 (iv) confinement in a private room to the extent it is
14 in excess of the institution's charge for its most common
15 semiprivate room, unless the private room is prescribed as
16 medically necessary by a physician;

17 (v) services or articles the provision of which is not
18 within the scope of authorized practice of the institution
19 or individual rendering the services or articles;

20 (vi) organ transplants unless prior approval is
21 received from the board of directors of the association;

22 (vii) room and board for a nonemergency admission on
23 Friday or Saturday;

24 (viii) pregnancy, except complications of pregnancy;

25 (ix) routine well baby care;

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(x) complications to a newborn, unless no other source of coverage is available;

(xi) sterilization or reversal of sterilization;

(xii) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

(xiii) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

(xiv) artificial insemination or treatment for infertility; or

(xv) breast augmentation or reduction.

Section 7. Certification of qualified plan. Upon application by the association or the lead carrier for certification of a plan of health coverage as a qualified plan for the purposes of [sections 1 through 12 13], the commissioner shall make a determination within 90 days as to whether the plan is qualified. If determined to be qualified, the plan of health coverage must be labeled as a "qualified plan" on the front of the policy.

Section 8. Association plan premium. The association shall establish the schedule of premiums to be charged eligible persons for membership in the association plan. The schedule of premiums may not be less than 150% or more than 400% of the average premium rates charged by the five largest insurers with the largest individual qualified plan of insurance in force in this state. The premium rates of

the five insurers used to establish the premium rates for each type of coverage offered by the association must be determined by the commissioner from information provided annually by all insurers at the request of the commissioner. The information requested must include the number of qualified plans or actuarial equivalent plans offered by each insurer, the rates charged by the insurer for each type of plan offered by the insurer, and any other information the commissioner considers necessary. The ~~commissioner~~ ASSOCIATION shall utilize generally acceptable actuarial principles and structurally compatible rates.

Section 9. Operation of association plan. (1) Upon acceptance by the lead carrier under [section 12], an eligible person may enroll in the association plan by payment of the association plan premium to the lead carrier.

(2) Not less than ~~90%~~ 88% of the association plan premiums paid to the lead carrier may be used to pay claims and not more than ~~10%~~ 12% may be used for payment of the lead carrier's direct and indirect expenses as specified in [section 10].

(3) Any income in excess of the costs incurred by the association in providing reinsurance or administrative services must be held at interest and used by the association to offset past and future losses due to claims expenses of the association plan or be allocated to reduce

1 association plan premiums.

2 (4) Each participating member of the association shall
3 share the losses due to claims expenses of the association
4 plan for plans issued or approved for issuance by the
5 association and shall share in the operating and
6 administrative expenses incurred or estimated to be incurred
7 by the association incident to the conduct of its affairs.
8 Claims expenses of the association plan that exceed the
9 premium payments allocated to the payment of benefits are
10 the liability of the association members. Association
11 members shall share in the claims expenses of the
12 association plan and operating and administrative expenses
13 of the association in an amount equal to the ratio of:

14 (a) the association member's total disability
15 insurance premium received from or on behalf of Montana
16 residents divided by;

17 (b) the total disability premium received by all
18 association members from or on behalf of Montana residents,
19 as determined by the commissioner.

20 (5) The association shall make an annual determination
21 of each association member's liability, if any, and may make
22 an annual fiscal yearend assessment if necessary. The
23 association may also, subject to the approval of the
24 commissioner, provide for interim assessments against the
25 association members as may be necessary to assure the

1 financial capability of the association in meeting the
2 incurred or estimated claims expenses of the association
3 plan and operating and administrative expenses of the
4 association until the association's next annual fiscal
5 yearend assessment. Payment of an assessment is due within
6 30 days of receipt by an association member of a written
7 notice of a fiscal yearend or interim assessment. Failure
8 by a contributing member to tender to the association the
9 assessment within 30 days is grounds for termination of
10 membership. An association member that ceases to do
11 disability insurance business within the state remains
12 liable for assessments through the calendar year during
13 which disability insurance business ceased. The association
14 may decline to levy an assessment against an association
15 member if the assessment, as determined pursuant to this
16 section, would not exceed \$10.

17 (6) Any annual fiscal yearend or interim assessment
18 levied against an association member may be offset, in an
19 amount equal to the assessment paid to the association,
20 against the premium tax payable by that association member
21 pursuant to 33-2-705 for the year in which the annual fiscal
22 yearend or interim assessment is levied. The ~~department-of~~
23 revenue INSURANCE COMMISSIONER shall, each year the
24 legislature meets in regular session, on or before January
25 15, report to the legislature the total amount of premium

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1 tax offset claimed by association members during the
2 preceding biennium.

3 Section 10. Administration of association plan --
4 rules. (1) Any member of the association may submit to the
5 commissioner policies to be proposed to serve as the
6 association plan. The commissioner shall prescribe by rule
7 the time and manner of the submission.

8 (2) Upon the commissioner's approval of the policy
9 forms and contracts submitted, the association shall select
10 policies and contracts by a member or members of the
11 association to be the association plan. The association
12 shall select one lead carrier to issue the qualified plans.
13 The board of directors of the association shall prepare
14 appropriate specifications and bid forms and may solicit
15 bids from licensed administrators and the members of the
16 association for the purpose of selecting the lead carrier.
17 The selection of the lead carrier must be based upon
18 criteria established by the board of directors.

19 (3) The lead carrier shall perform all administrative
20 and claims payment functions required by this section upon
21 the commissioner's approval of the policy forms and
22 contracts submitted. The lead carrier shall provide these
23 services for a period of at least 3 years, unless a request
24 to terminate is approved by the association and the
25 commissioner. The association and the commissioner shall

1 approve or deny a request to terminate within 90 days of its
2 receipt. A failure to make a final decision on a request to
3 terminate within the specified period is considered an
4 approval. The association shall invite submissions of policy
5 forms from members of the association, including the lead
6 carrier, 6 months prior to the expiration of each 3-year
7 period. The association shall follow the procedure provided
8 in subsection (2) in selecting a lead carrier for the
9 subsequent 3-year period or, if a request to terminate is
10 approved, on or before the end of the 3-year period.

11 (4) The lead carrier shall provide all eligible
12 persons involved in the association plan an individual
13 certificate setting forth a statement as to the insurance
14 protection to which the person is entitled, the method and
15 place of filing claims, and to whom benefits are payable.
16 The certificate must indicate that coverage was obtained
17 through the association.

18 (5) The lead carrier shall submit to the association
19 and the commissioner on a semiannual basis a report of the
20 operation of the association plan. The association must
21 determine the specific information to be contained in the
22 report prior to the effective date of the association plan.

23 (6) The lead carrier shall pay all claims pursuant to
24 [sections 1 through ~~12~~ 13] and shall indicate that the claim
25 was paid by the association plan. Each claim payment must

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1 include information specifying the procedure involved in the
2 event a dispute over the amount of payment arises.

3 (7) The lead carrier must be reimbursed from the
4 association plan premiums received for its direct and
5 indirect expenses. Direct and indirect expenses include a
6 prorated reimbursement for the portion of the lead carrier's
7 administrative, printing, claims administration, management,
8 and building overhead expenses, which are assignable to the
9 maintenance and administration of the association plan. The
10 association must approve cost accounting methods to
11 substantiate the lead carrier's cost reports consistent with
12 generally accepted accounting principles. Direct and
13 indirect expenses may not include costs directly related to
14 the original submission of policy forms prior to selection
15 as the lead carrier.

16 (8) The lead carrier is, when carrying out its duties
17 under [sections 1 through 13], an ~~agent-of~~ INDEPENDENT
18 CONTRACTOR FOR the association and is ~~civilly~~ INDIVIDUALLY
19 liable for its actions, subject to the laws of this state.

20 Section 11. Solicitation of eligible persons. (1) The
21 association, pursuant to a plan approved by the
22 commissioner, shall disseminate appropriate information to
23 the residents of this state regarding the existence of the
24 association plan and the means of enrollment. Means of
25 communication may include use of the press, radio, and

1 television, as well as publication in appropriate state
2 offices and publications.

3 (2) The association shall devise and implement means
4 of maintaining public awareness of [sections 1 through 12
5 13] and shall administer [sections 1 through 12 13] in a
6 manner which facilitates public participation in the
7 association plan.

8 (3) All licensed disability insurance agents may
9 engage in the selling or marketing of qualified association
10 plans. The lead carrier shall pay an agent's referral fee of
11 \$25 to each licensed disability insurance agent who refers
12 an applicant to the association plan, if the applicant is
13 accepted. The referral fees must be paid to the lead
14 carrier from money received as premiums for the association
15 plan.

16 (4) An insurer, society, or health service corporation
17 that rejects or applies underwriting restrictions to an
18 applicant for disability insurance must notify the applicant
19 of the existence of the association plan, requirements for
20 being accepted in it, and the procedure for applying to it.

21 Section 12. Enrollment by eligible person. (1) The
22 association plan must be open for enrollment by eligible
23 persons. An eligible person may enroll in the plan by
24 submission of a certificate of eligibility to the lead
25 carrier. The certificate must provide:

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(a) the name, address, and age of the applicant and length of the applicant's residence in this state;

(b) the name, address, and age of spouse and children, if any, if they are to be insured;

(c) written evidence that he fulfills all of the elements of an eligible person, as defined in [section 1]; and

(d) a designation of coverage desired.

(2) Within 30 days of receipt of the certificate, the lead carrier shall either reject the application for failing to comply with the requirements of subsection (1) or forward the eligible person a notice of acceptance and billing information. Insurance is effective ~~immediately upon receipt of the first month's association plan premium and is retroactive to the date of application, if the applicant otherwise complies with {sections 1 through 12}~~ ON THE FIRST OF THE MONTH FOLLOWING ACCEPTANCE.

(3) An eligible person may not purchase more than one policy from the association plan.

(4) A person who obtains coverage pursuant to this section may not be covered for any preexisting condition during the first 12 months of coverage under the association plan if the person was diagnosed or treated for that condition during the 5 years immediately preceding the filing of an application. This subsection does not apply to

a person who has had continuous coverage under an individual, family, or group policy during the year immediately preceding the filing of an application for nonelective procedures.

(5) A CHANGE OF RESIDENCE FROM MONTANA TO ANOTHER STATE IMMEDIATELY TERMINATES ELIGIBILITY FOR RENEWAL OF COVERAGE UNDER THE ASSOCIATION PLAN.

SECTION 13. LIABILITY OF ASSOCIATION MEMBERSHIP. NO MEMBER OF THE ASSOCIATION IS LIABLE FOR THE ACTIONS OF THE ASSOCIATION OR ITS LEAD CARRIER.

Section 14. Extension of authority. Any existing authority of the commissioner of insurance to make rules on the subject of the provisions of this act is extended to the provisions of this act.

Section 15. Codification instruction. Sections 1 through ~~12~~ 13 are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to sections 1 through ~~12~~ 13.

Section 16. Severability. If a part of this act is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of this act is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

Section 17. Effective date. (1) Except for section 5,

HB 0817/03

1 this act is effective July 1, 1985.

2 (2) Section 5 is effective July 1, 1987.

-End-